Chapter 7

Health Professionals on the Front-Line

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Asian Pacific Americans are disproportionately involved in the struggle to deliver decent health care to the poor in the urban inner-cities. While Asian Pacific Americans comprise only 3 percent of the total population, they represent nearly a quarter of the health care providers in the public hospitals in our largest metropolitan areas. For many, these health professions are the primary source of service in a fragile and under-financed system. As the first section of this chapter documents, an unacceptable number of our citizens do not have the personal resources to access services in a huge and sophisticated health industry. Unequal access to services is a part of the broader social and economic polarization afflicting this country, with income and race serving as strong determinants of people's ability to receive timely and effective treatment. The tragic consequences of this inequality are glaring in our metropolitan areas, which house large concentrations of the medically underserved. The herculean task of serving this population has fallen on public hospitals, which are discussed in the second section of this chapter. These front-line facilities are underfunded, understaffed, and overwhelmed, creating a system that is short on supplies, chaotic, and inefficient.

The third section of this chapter documents the factors that have made Asian Pacific Americans an increasingly important source of health care professionals for these facilities, and for the country as a whole. The key factors are high rates of graduation from American medical and nursing schools and high rates of immigration of foreign-trained practitioners. The latter factor

plays a central role in the concentration of Asian Pacific medical personnel in the public hospitals of America's largest metropolitan areas. As the data in the fourth section of this chapter show, they constitute as much as a quarter of the physicians and nurses.

Stratified Health Care Privileges

America's health system is both one of the world's most advanced and most primitive. During the post-World War II period, per capita expenditure on medical services increased by six-fold in real dollars, from $371 in 1949 to $2,227 in 1992.[1] This expenditure places this nation well ahead of most other advanced economies.[2] It is estimated that this nation's health expenditures will reach one trillion dollars in 1994. As a percent of total expenditure, medical services grew from 5 percent to 14 percent. This has enabled Americans to afford cutting-edge technology and highly specialized health care providers and researchers. Many with once crippling or fatal diseases now enjoy an opportunity to live a better and longer life.

While many Americans enjoy unparalleled health care, others have, at best, limited access. America's health system is hierarchical with disparate sets of privileges. Some communities, particularly in the inner-cities, have less than a tenth of the resources available to their more affluent counterparts. The consequences are localized morbidity and mortality statistics closer to that of under-developed economies than of industrialized economies.[3]

The two groups that have benefitted greatly from growth of the health system are workers and their families who receive health insurance coverage through employment, and the elderly who are covered by Medicare. Employer-provided coverage grew rapidly throughout this period, stimulated at various times by wage control, favorable tax laws, and union demand. By the late 1980s and early 1990s, the majority of Americans received health insurance coverage from an employer-provided program.

The elderly are primarily covered by Medicare, a federally operated insurance program started in 1966 to provide hospitalization and other coverage. Today, Medicare accounts for over half of all federal health dollars, which includes direct benefits and research. Despite some flaws, this program has provided

the elderly poor with far greater security than available to many others. This program, along with Social Security, has been one of this nation's major successes in the social policy area. By ensuring decent access to health care, Medicare has provided elderly access to a disproportionately large share of health services.[4]

In contrast, those not covered by private health insurance or Medicare are poorly served by the health system. This group can be divided into two populations. (See Table 1 for estimates of these populations.) The first group includes those on public assistance, particularly Aid to Families with Dependent Children, who are included in the federal-state Medicaid program.[5] This program, which also started in 1966, has had difficulties providing minimal basic health care to the poor. The eligibility requirements mean that Medicaid does not cover all poor people. Over the last decade, only half of those living in families below the federal poverty level were covered by Medicaid, and by the early 1990s, less than half were. Even participation in Medicaid does not guarantee adequate access to health care. Only a third of all physicians fully participate as providers.[6] This low rate is not surprising given that reimbursements for Medicaid patients are generally less than two-thirds of the rate that private insurance companies pay doctors for non-Medicaid patients (*U.S. News and World Report*, September 20, 1993). In major metropolitan areas such as New York City, the reimbursement rate for some basic services can be as low as a quarter of the cost of providing the care; consequently, in 1989, less than a sixth of the medical doctors billed Medicaid for services, with most of them working out of clinics and outpatient departments of hospitals, rather than private offices (Berliner, 1993, p. 30).

Finally, there is a large and growing population of the uninsured, who are only a serious illness away from becoming financially devastated. Nearly 17 percent of the population in 1991 below age 65 were uninsured,[7] and the uninsured rate among the poor was over twice as high as the non-poor. Six in ten of the uninsured live in households that have incomes less than twice the official poverty line.[8] This sizable uninsured population has no counterpart in other Western industrialized economies, where almost everyone enjoys some form of health insurance coverage. The majority of the 37 million uninsured Americans,

Table 1. Health Insurance Status, Non-Elderly Population

	Private Coverage	Other Coverage	Medicaid Only	Un-insured
All Persons	72%	3%	8%	17%
By Income Status*				
Poverty	21%	4%	42%	33%
Low Income	57%	5%	9%	29%
Others	88%	2%	1%	10%
By Race				
Non-Hispanic White	80%	3%	5%	13%
African American	50%	5%	21%	24%
Latino	47%	2%	16%	35%
Asian Pacific Islander	70%	3%	7%	20%
By Metropolitan Size**				
Large	67%	2%	11%	20%
Medium	75%	1%	7%	16%
Small	79%	2%	6%	12%

* Those classified as being in poverty lived in families with an income below the federal poverty line; low-income individuals lived in families with an income between 1 to 1.99 times the poverty line; all others lived in families with an income at least twice the poverty line.

** Large metropolitan areas include MSAs of at least three million persons; medium metropolitan areas include MSAs of at least one million to less than three million; and small metropolitan areas include all other MSAs.

Source: Tabulations by authors from March 1992 Current Population Survey.

perhaps as much as 86 percent, are workers and their families, and most can be classified as the working poor. They work for firms that do not or cannot afford to provide health benefits. This is a population that has grown dramatically in recent years as income polarization increased, and as more firms eliminate or reduce health insurance coverage as a part of their restructuring.

Not having insurance or being poor has a marked impact on usage rates and health care seeking. A 1986 survey revealed that despite their worse health conditions, the poor were less likely to receive health care, and that the uninsured were almost twice as likely to be without a regular source of care than the insured (Freeman et al., 1987; Weisfeld, 1987). An analysis of the 1989 National Health Interview Survey shows that the uninsured were less likely to receive health care than the insured, and this was especially true of the chronically ill.[9]

The lack of financial resources does not allow the poor and uninsured to practice preventive medicine or seek a regular source of primary or ambulatory care. They are crisis-oriented, using health care facilities sporadically and often inappropriately, such as hospital emergency departments for non-critical conditions (Hawkins and Higgins, 1989, p. 132). Although many of the poor pay at least some of their health related costs, there are millions who cannot pay. This medically indigent population, usually made up of low-income, uninsured persons, generates billions of dollars worth of uncompensated health care costs each year.

America's major cities have a large share of those on public assistance or the uninsured. According to estimates from Current Population Survey data, this medically underserved group comprise nearly a third of the population in metropolitan areas with at least three million persons, which is a substantially higher ratio than in small metropolitan areas. The problem in the largest metropolitan areas is even greater. In Chicago, 1.4 million persons in 1991, representing 25 percent of the non-elderly population, were either uninsured or had Medicaid only. New York City had 2.7 million persons, comprising 37 percent of the non-elderly population, who fell into this category. And Los Angeles had the highest uninsured/Medi-Cal rate among the major metropolitan areas, with 3.4 million comprising 40 percent of the total non-elderly population.

Within the large urban areas, those on Medicaid or uninsured

are heavily concentrated in poor neighborhoods that have few health care providers. This is ironic because there is no shortage of providers in these metropolitan areas. These cities have a disproportionately large number of providers because of the presence of a sizable affluent population, medical schools, and hospitals that serve a national or even international clientele. Nonetheless, a physician surplus coexists with a physician shortage. In New York City, private physicians concentrate in primarily wealthy areas of the city, while low-income areas of the city are medically underserved because physicians are reluctant to set up practice there (Berliner, 1993, p. 30).

This pattern of avoidance by private providers can be found in every major city and has led to a great disparity, where the ratio of private practitioner to the population in an affluent neighborhood can be as high as 1:150, while that for the poor section of the city can be 1:15,000 (Ginzberg, Berliner, and Ostow, 1993, p. 7). Chicago is an example of this: it has an overall physician/population ratio of about 1:850 persons, but the ratio in the shortage areas may be as high as 1:16,000 or 17,000 (Salmon, 1993). Similar disparities can be found in Los Angeles, where the physician to population ratio in affluent Beverly Hills is ten times lower than in low-income Watts (Brown and Dallek, 1993, p. 122). Programs that subsidized the training of physicians or some of their operating costs in exchange for a promise of serving "underserved areas" have had limited success (Berliner, 1993, p. 31).

The problems facing the medically underserved have worsened over the last few years as the poor and uninsured have become victims of cost containment. Private insurance and federal spending raise demand so rapidly that the cost of providing medical care outpaces the overall rate of inflation. Between 1950 and 1991, overall prices (as measured by the Consumer Price Index for urban residents) increased by 465 percent, while medical care increased by 1,072 percent. This excessive inflation has seriously cut the purchasing power of the dollars spent on health care and partially accounts for the increasing burden of medical care on the whole economy. The threat of runaway health care spending has led to efforts to contain cost.

Public sector efforts to control prices have been limited to setting

reimbursement rates for programs funded by the federal government and by the states.[10] The alternative has been to cut spending. While attacking Medicare has proven to be politically unfeasible, the same was not true for other health programs. Congress, under the Reagan Administration, reduced federal funding of Medicaid, shifting greater responsibility for program administration to the states. The net effect was the reduction of health coverage for the poor and near poor during the decade of the eighties. According to Ginzberg, Berliner, and Ostow (1993), over 60 percent of persons at or below federal poverty level were covered by Medicaid in the mid-1970s. By the early 1990s, this number had been reduced to 44 percent. The impact clearly showed up in the National Access Surveys of 1982 and 1986, which revealed a reduction in access to health care for the poor (Freemen et. al, 1987; Weisfeld, 1987).

State governments have also pursued cost cuts, partly by shifting or unloading responsibilities to local jurisdictions, as illustrated by the case in California (Brown and Cousineau, 1987). In a major effort to cut back health care programs, the state removed 250,000 people from Medi-Cal in the early 1980s, and transferred the responsibility for their care to the counties, which were also having fiscal difficulties. In return, the counties received only 70 percent of what the state would have spent for patient care under Medi-Cal. With declining public revenues, this shifting and whittling of responsibility among different levels of government has continued.

Public Hospitals

For many urban poor, locally funded hospitals serve as their primary source of medical care (King, 1989), and, in turn, these public facilities serve a disproportionate share of this population (Bindman et al., 1990). In California, for example, county hospitals served 44 percent of Medicaid patients and 66 percent of the uninsured in 1988. In neighborhoods suffering from a paucity of private practitioners, public hospitals are on the front-line of providing care to the economically disadvantaged. Unfortunately, this system is under fire, overwhelmed by large and growing numbers of patients and squeezed by limited and often declining funds.

The challenges facing Los Angeles County, which has six

hospitals and 45 health centers, illustrate the problems facing the local public health system. The County operates the second largest public health system in the nation, providing nearly one million inpatient days, three million outpatient visits, and 400,000 emergency room visits per year to its population (Los Angeles County, Department of Health Services, 1992). The County has three large inner-city hospitals — Martin Luther King-Drew, Harbor-UCLA, and County General-USC — located in low- or moderate-income neighborhoods that are predominantly black or Latino.

Patient care at these inner-city facilities is at best inadequate. They are so poorly funded and understaffed that they are unable to meet the legally required quality of medical care for the indigent (Dallek, 1987; Brown, Aneshensel, and Pollack, 1993). The problem is aggravated by the private sector which has over time been less willing to provide uncompensated health care. The consequence of this diversion of indigent patients to public hospitals, along with other factors, is "to create more pressures upon the public sector health services system" (County of Los Angeles, Department of Health Services, 1992, p. 62). With limited capacity and a large population in need, the county's hospitals typically operate at 90-100 percent occupancy.

Understaffing and limited resources directly translate into poor or inadequate service (Dallek, 1987). Care is often delayed or cut short. The average waiting time in the emergency rooms is more than six hours. At times, there are often two nurses for as many as 50 emergency room patients. These shortages force emergency-room physicians to perform nursing functions. Patients who need critical beds often wait as long as three days in the emergency room. Non-emergency care is also poor. Cardiology patients who should be seen every one to two weeks are scheduled at three to six month intervals because of patient load, and the wait for an appointment at the Gynecology and Internal Medicine Clinics can be up to three months. The quality of care at one facility was so poor in 1989 that it was in danger of losing its accreditation.[11] It had one of the worst mortality rates in the nation, particularly among newborns.

The conditions in Los Angeles are not unique. In New York City, the public hospitals, which are operated by the New York

City Health and Hospital Corporation, a quasi-public agency, provide services to the majority of patients who are uninsured poor or on Medicaid (Berliner, 1993, p. 34). This distribution is due in part to private hospitals shifting (dumping) uninsured patients to the public sector. Unfortunately, the public facilities "are understaffed, operate with obsolete or broken equipment, and do not function with a high level of competency" (Berliner, 1993, p. 25). Moreover, the number of these facilities has declined, down from 13 to 11, leading to a corresponding decrease of 1,000 acute-care beds. The quality of care faced by the poor in Chicago's public hospitals is no better than that in the other two metropolitan areas. Despite large sums of new funds for capital and other types of improvements, there has been no noticeable progress, in part because of bureaucratic inefficiency and waste (Salmon, 1993, pp. 53, 79) The services that are provided are often substandard (Salmon, 1993, p. 80).

As indicated above, the lack of adequate funding adversely affects staffing. Employment issues vary by professions. Public hospitals have less difficulties hiring physicians than nurses, but these hospitals face other problems with their medical staff. The New York City Health and Hospitals Corporation, for example, has found it easy to fill its staff positions because of two possible reasons: "a physician surplus or, alternatively, simply of the difficulties of starting a private practice" (Berliner, 1993, p. 32). However, the type of doctors that they can recruit is limited by the low pay and stress associated with working in an overloaded system. The 1990 Census data for four metropolitan regions (Southern California, the greater San Francisco Bay area, Chicago, and New York) indicate that the typical physician in public hospitals earns only three-quarters of that of the typical physician in private hospitals, and less than two-fifths of the typical physician in the non-hospital in the private sector.[12]

A part of the discrepancy in earnings can be attributed to the greater use by public hospitals of younger or recently graduated doctors, many of whom are still in training, and to the hiring of foreign medical graduates, who have relatively fewer opportunities to practice elsewhere. While 36 percent of the physicians in private practice in four of the largest metropolitan regions are 40 years or older, only 28 percent of the physicians in public hospitals are.[13] Moreover, nearly half (47 percent) of the physicians in

these facilities are immigrants. Consequently, in many poor communities, young and immigrant physicians in public hospitals are their sole source of medical service given the paucity of private physicians.

For the nursing staff, public hospitals have great difficulties recruiting personnel. This matter is not unique to these facilities. The United States has been plagued by recurrent nursing shortages since as early as 1915 (King, 1989; Flanagan, 1976; Carlson, Coward, and Speake, 1992). A review of the record shows that from the fifties to the eighties, the country experienced seven serious shortages (nursing vacancy rates of 10 percent or more in hospitals), each one lasting from one to three years (McKibbin, 1990). The most recent one continued to the end of the last decade, proving to be "the most persistent and prolonged" shortage in four decades. It has taken the severe and protracted recession of the early nineties to eliminate this shortage.

The shortages have occurred despite a phenomenal growth in the number of nurses from 600,000 in 1960 to over two million by the late 1980s. The shortage is partly due to the rapid growth in the health care industry, creating a dynamic shortage. There is also a cyclical component, with severe shortages during expansionary periods when demand for services is high. Government programs designed to increase the number through educational subsidies and reforming nursing education have helped but have proved insufficient. The shortage is due to the unattractiveness of the occupation. Wages have been held down by monopsony behavior by hospitals and by pervasive gender discrimination in our society. Moreover, working conditions are poor. Life on a hospital floor, where the vast majority work, is very stressful and nurses lack the autonomy that characterizes medical professionals because the medical system subordinates them to physicians. These factors have not only made the profession undesirable for many, but also have generated high turnovers and burnouts. Therefore, it is not surprising that there is a recurring shortage.

Within the nursing market and its recurring shortages, public hospitals are at a disadvantage, despite often offering prevailing wages. Given that working conditions in the public sector are less desirable, public hospitals must offer a compensating

premium to stay competitive. Unfortunately, there is no real difference between those working in public and private hospitals.[14] Without a compensating differential, it is not surprising that public hospitals tend to have higher vacancy rates than their private counterparts, a problem that persists even when the shortage is abating in the private sector.

Asian Pacific American Health Care Providers

Over the last quarter century, Asian Pacific American health care professionals have emerged as a noticeable and growing labor force. While Asian Pacific Americans comprise 3 percent of the total population in 1990, they comprise 4.4 percent of the registered nurses and 10.8 percent of the nation's practicing physicians.[15] They are not only disproportionately overrepresented in these two medical fields, but their numbers grew at a phenomenal rate, by approximately seven-fold and five-fold, respectively, since 1970.[16] The Asian Pacific providers can be divided into two groups, those educated in the United States and those trained abroad.

Given that Asian Pacific Americans have extremely high rates of college and university attendance, as discussed in Chapter 3, it is not surprising that a large number have been graduating from U.S. health programs. Their share depends on the relative prestige of the degree and occupation. The percentage from all reporting registered nurse programs, which include those in community colleges and in hospitals, was 1.9 percent in 1989 and grew modestly to 2.5 percent in 1991. However, the percentage of Asian Pacific Americans graduating from baccalaureate nursing programs is both higher and growing more rapidly, from 2.3 percent in 1989 to 4 percent in 1991. The statistics for medical graduates are even more impressive. Between the late 1970s to the mid-1980s, the Asian Pacific share grew from 2 percent to 6 percent, and by 1991 the statistic stood at 11 percent.[17]

Despite the disproportionate numbers graduating from domestic medical and nursing programs, Asian Pacific American health providers who were educated in the U.S. comprise only a small part of the total Asian Pacific health care labor force. The significant presence of Asian Pacific Americans in U.S. medical and nursing schools is a recent phenomenon. With continuing high rates of graduation, U.S.-educated professionals will

become an increasingly important source of providers in the future; however, they are in the minority today. Estimates based on the 1990 Census indicate that only roughly a third of the working Asian Pacific physicians were educated in this country, and approximately half of these were either born in the U.S. or were children when they immigrated to the United States.[18] The corresponding statistics for nurses are even lower, with approximately a quarter receiving a U.S. education and roughly half of these being either born in the U.S. or children when they immigrated to the United States.[19]

Despite the imprecision of the data, the estimates clearly reveal that immigration over the last quarter century has been the major source of today's Asian Pacific health care providers. This is not a new phenomenon, although there have been changes in the sending countries. Graduates of foreign medical and nursing schools have been an important part of the U.S. health care system since shortly after World War II. The passage of the Smith-Mundt Act of 1946 created the exchange visitor (J-1) visa category, which enabled health care professionals (and others) to enter this country on temporary basis for educational purposes, primarily to receive training as interns and residents. For some, this became an avenue for permanent immigration;[20] however, other regulations prevented Asians from taking extensive advantage of this provision, and Europeans comprised the bulk of the temporary visitors as well as the permanent immigrants. This racial bias was eliminated with the passage of the Immigration and Naturalization Act of 1965, which dropped the discriminatory national quotas and created preferential categories for certain occupations.

During the late 1960s and early 1970s, when there was a physician shortage in the country, medical graduates received preferential treatment in their application for immigration, temporary worker, or exchange visitor visas. The impact of this favorable treatment can be seen in the increase in numbers of foreign medical graduates (FMGs). Even before the 1965 Immigration Act, FMGs grew from 6 percent of the total numbers of physicians in 1959 to 10 percent in 1963 (Leibowitz, 1988, p. 2). By 1976, there were 85,456 FMGs, comprising 21 percent of the total numbers of physicians.[21]

When the shortage turned into a surplus, the favorable treatment

accorded to foreign medical graduates (FMGs) disappeared. The Health Professions Educational Assistance Act of 1976 made it more difficult for FMGs, eliminating the blank labor-certification that had previously enabled them to receive an occupational visa based on their training, and adding an examination to screen potential exchange visitors and immigrants (U.S. Commission on Civil Rights, 1980). FMGs could continue to apply for an occupation-based immigrant visa, but only on a case-by-case basis, which required sponsors to prove that positions could not be filled by U.S. workers. In practice, this limited occupational immigrants to positions in geographic areas or specialties with shortages. The post-1976 restrictions slowed rather than stopped the flow of FMGs. By 1986, there were over 123,090, comprising 22 percent of all physicians. In 1986, after an analysis indicated that a majority of immigrants who had entered via occupational visas no longer practiced in a shortage area, the U.S. stopped granting immigration visas based on the shortage criterion. However, even with this decision, nearly 9,000 physicians were able to enter the country during the 1989, 1990, and 1991 fiscal years. The most recent figures show that FMGs still comprise 21 percent of all U.S. physicians (Roback et al., 1992), indicating that international flow of these professionals has roughly kept up with the expanding pool of physicians in the United States.

Asian nations have been one of the major sources of FMGs. Prior to the mid-1960s, most FMGs were from Europe, but with the end of the biased quota system, the flow from Asia grew. In the early seventies, as many as 5,000 Asian Pacific FMGs entered annually as immigrants (U.S. Commission on Civil Rights, 1975). In 1971, they comprised 77 percent of medical exchange visitors. Their share of newly-arriving immigrant physicians and surgeons was equally large, over two-thirds during the early 1970s. Between 1972 and 1985, 29,843 physicians from the major Asian Pacific sending countries (India, the Philippines, Korea and China, Hong Kong, and Taiwan) immigrated to the U.S. (Ong, Cheng, and Evans, 1992). By the early 1980s, Asian Pacific FMGs comprised nearly half of the total stock of the FMG population (Eiler and Loft, 1986). Even under the more stringent regulations after 1986, immigration has continued, as shown in Table 2. For the three fiscal years (1989,

1990, and 1991), 4,453 physicians from Asian Pacific countries became permanent immigrants, over half of all such immigrants. Only one in ten came through the occupational preference categories, while the vast majority came through family sponsorship.

The immigration of foreign-nurse graduates (FNGs) has followed a different pattern than that of FMGs. The policies governing the movements of FNGs have been shaped by recurring and endemic shortages of registered nurses described earlier. This labor shortage has contributed to a continuing preferential treatment for FNGs both as immigrants and as temporary workers. Unlike physicians, where the exchange-visitor is important for non-immigrants, the H-1 category, which gives persons the right to work in the United States on a short-term basis, has been important for FNGs. Nursing has not only continued to qualify

Table 2. Immigrant Health Care Providers by Country of Birth Fiscal Years 1989, 1990, 1991

	Physicians	Nurses	Other Health Occup.
Total, All Countries	8,798	18,888	10,901
Philippines	901	9,875	2,862
India	1,424	1,003	570
People's Republic of China	807	460	318
Korea	78	285	141
Taiwan	249	193	278
Hong Kong	95	201	175
Other Asian	899	324	585
Total Asian	4,453	12,341	4,929
All Others	4,345	6,547	5,972

Source: Tabulations by authors from INS Tapes

persons for H-1 sponsorship, but FNGs have received relatively more access to labor certification for the purpose of qualifying for permanent immigration than physicians in the post-1976 period. Moreover, the federal government responded to the shortage of nurses in the late 1970s and parts of the 1980s by allowing temporary workers to prolong their stay in the country for as long as six years. But even this proved to be insufficient in the late 1980s because of the potential losses from those whose visas would expire, even with the extensions. Congress acted by passing Immigration Nursing Relief Act of 1989 (INRA), which allows nurses who entered the U.S. with H-1 visas before September 1, 1989, and have worked in nursing for three years, to adjust to permanent status without regard to per country caps on immigration.

Despite the favorable treatment of FNGs, foreign-trained nurses make up only a fraction of the nursing work force, less than a tenth in 1990.[22] Where they are important is in selective hospitals suffering from severe shortages, such as the inner-city facilities in older metropolitan areas facing fiscal difficulties. These hospitals have actively recruited nurses from throughout the world, using their own recruiters and outside agencies based both in the United States and abroad. Although many hospitals favor FNGs from Western countries such as Great Britain and Canada, Asia has been the largest source of foreign nurses.

This trend is clearly evident among both the temporary and permanent immigrants. In the late 1960s, Asians comprised four out of every five nurses on J-1 visas, which was then the primary mode of entry for non-immigrant nurses. This pattern continued after H-1 visas (temporary work visas) replaced J-1 visas. In the late 1980s, Asians comprised over three-quarters of all H-1 nurses. There has also been an equally remarkable change among nurses who are permanent nurses. In 1966, 10 percent of immigrant nurses were from Asia, but by the late 1980s and early 1990s, three-quarters were. The immigration of Asian Pacific nurses first reached a high point in the seventies when their numbers doubled from 1,768 at the beginning of the decade, comprising 36 percent of all nurses entering under the professional category, to 34,576 in 1974 when they comprised 65 percent of all immigrating nurses. Altogether, roughly 37,000 registered nurses immigrated from just four Asian sending

countries between 1972 and 1985 (Ong, Cheng, and Evans, 1992). As Table 2 shows, this high rate of immigration continued, with over 12,000 entering during the fiscal years of 1989, 1990, and 1991. Over a third were adjusters who took advantage of the 1989 Immigration Nurse Relief Act, and another quarter entered through the occupational quotas. The combination of temporary and permanent immigration has left its mark. By the late 1980s, over three-quarters of the foreign-trained nurses in the U.S. were Asian Pacific (1988 National Sample Survey of Registered Nurses).

Although there are FNGs from throughout the Asia Pacific region, the Philippines is the biggest supplier of nurses to the U.S. Nearly 25,000 Filipino nurses immigrated to the U.S. between 1966 and 1985. Almost 10,000 Filipino nurses immigrated between 1989 and 1991, comprising more than half of all nurse immigrants for that period. The dominance of Filipino nurses among those with temporary working visas is also great. Almost three-fourths of all H-1 nurses are from the Philippines (Interpreter Releases, 1989). In all, between two-thirds and three-quarters of the Asian Pacific FNGs are from the Philippines.[23]

Asian Pacific Americans on the Front-Line

Asian Pacific Americans are not only overrepresented at the national level in the medical and nursing professions, but they are especially overrepresented in the public hospitals of major metropolitan areas.[24] This pattern is due in part to self-selection by Asian Pacific Americans, both U.S.-and foreign-educated practitioners. Because of their professional standing and the values and lifestyle that accompany this education and economic position, many prefer to live and practice in cosmopolitan cities. Moreover, the large metropolitan areas offer a rich cultural life and large Asian Pacific communities that cater to ethnic-specific needs. However, this self-selection process is only one factor.

Immigration is a primary factor in producing the relatively high numbers in medical professions. As stated earlier, the immigration law provided, and in some cases still provides, preferential consideration to the highly-skilled. Hospitals in major metropolitan areas have been major sponsors of both temporary workers and permanent immigrants. During the

seventies, many of these hospitals, particularly those not directly affiliated with U.S. medical schools, filled their positions for medical residents with foreign graduates (Salmon, 1993, p. 81). Many hospitals in New York and Chicago responded to the nursing shortage in the late 1980s by recruiting nurses from foreign countries (Berliner, 1993, p. 32; Salmon, 1993, p. 73). By the late 1980s, a quarter of registered nurses in New York City were foreign-trained, about half of them on temporary visas.[25]

The foreign-educated professionals in the metropolitan hospitals provide crucial services, particularly to the poor. In general, FMGs served a disproportionately larger share of disadvantaged patients and saw more Medicaid patients than other physicians (Studnicki et al., 1976; Swearinger and Perrin, 1977). This is due in part to their presence in FMG-dependent hospitals. Those facilities that have FMGs comprising at least a quarter of their medical staff tend to have a larger share of Medicaid patients (Leibowitz, 1988, p. 29).

FNGs also provide crucial services in the hospitals. According to the Vice President of Nursing at Beth Israel Medical Center in New York City,

> (H-1 nurses) tend to be concentrated in certain services and units . . . the areas where there is the most significant risk of stress and burnout in the profession are the intensive care units and the medical/surgical services. Therefore, while every individual nurse is valuable, those working in these areas are virtually irreplaceable and of critical importance to our health care system.[26]

These nurses are so crucial that "if New York were to lose 5 percent of its nursing complement, neglect and mortality would accelerate and place an unconscionable strain on already overburdened U.S. nurses."[27] Their contributions are also indirect.

> Without foreign nurses, our already over-extended nurses would be unable to cope. Without the assistance that foreign nurses offer, many nurses would simply leave nursing for less stressful and less physically demanding jobs.[28]

The importance of H-1 is not limited to New York. In one Southern California Hospital, for example, half of 90 H-1 nurses

were working on critical care units, where they had 80 open positions.[29]

Many of these foreign-educated professionals in the metropolitan hospitals are Asian Pacific. For example, according to data gathered by the Philippine Nurses Association of America, Filipinos comprise 85 percent of H-1 nurses in New York City and 92 percent in New Jersey. The consequence of recruitment and hiring of Asian Pacific FMGs can be seen in the geographic patterns of recent immigrants. INS data for the fiscal years of 1989, 1990, and 1991 show that 42 percent of the physicians and 59 percent of the nurses settled in just four metropolitan areas: New York/Newark, Chicago, San Francisco/Oakland, and Los Angeles.[30]

The impact of this trend can also be seen in 1991 EEOC data for all hospitals in the four areas.[31] Asia-educated professionals, along with U.S.-educated Asian Pacific Americans are highly visible among the professional ranks: 21 percent in New York, 28 percent in Los Angeles, 24 percent in the San Francisco Bay area, and 13 percent in Chicago.[32] They, more often than not, comprised more than half of the minority professionals employed in hospital settings. Although the statistics include all Asian Pacific professionals, a large majority are foreign-educated.[33]

Among metropolitan hospitals, the public hospitals are more likely to use Asian Pacific health care providers. As stated earlier, financial constraints and poor working conditions have forced these facilities to recruit and hire foreign-trained professionals. Los Angeles County's Martin Luther King Hospital, which serves a predominantly low-income black and Latino community, exemplifies the growing dependency on Asian Pacific medical and nursing professionals. The Asian Pacific share grew from 27 percent in 1983 to 34 percent in 1989,[34] with the majority being Asian-educated practitioners. While most other public hospitals in major metropolitan areas are not as dependent, there is no question that Asian Pacific Americans are tremendously overrepresented, as shown in Table 3. Within the four metropolitan areas, Asian Pacific health practitioners comprise about a quarter of all physicians and nurses employed in local public hospitals.

Table 3. Ethnic Distribution of Health Professionals in Four Metropolitan Areas

	Asian Pacific Americans	Non-Hispanic Whites	Others
Physicians			
All	18%	70%	12%
Hospitals	21%	66%	13%
Public Hospitals	24%	53%	23%
Registered Nurses			
All	16%	61%	23%
Hospitals	19%	59%	22%
Public Hospitals	24%	37%	39%

Note: Statistics apply to those employed during the enumeration week for the 1990 Census.

Source: Tabulations from U.S. Bureau of the Census, 5% Public Use Microdata Sample, 1990.

Concluding Remarks

As we have seen, Asian Pacific Americans have assumed a disproportionate share of the responsibilities to provide health care in the public hospitals, and in this country's health system in general, and by doing so have contributed to the well-being of this nation. These responsibilities should be accompanied by a set of opportunities, which would benefit both the practitioners and their patients.

Practitioners should have the opportunity to improve their skills and practice good medicine. For foreign-educated professionals, many public hospitals are not equipped to provide the additional training needed to improve and refine skills. In the case of FNGs, the training can be crucial in determining whether they can pass the RN licensing exam and continue to practice in their chosen profession. Training alone, however, is insufficient. Public hospitals are plagued by poor service, but the quality of service is not related to the use of

foreign-educated practitioners. The quality of care appears to be affected by hospital characteristics rather than the presence of a FMG (Leibowitz, 1988). For nurses, a shortage of staff leads to a heavy workload, frustration and an inability to provide professional care (Spangler, 1991). The stress and understaffing found in many public hospitals may be contributing factors for the lower quality of service, as indicated by the earlier discussion on the facilities in Los Angeles.

Asian Pacific professionals should also have the opportunity to practice in a harmonious workplace. Unfortunately, cultural and language differences have created inter-group tensions on the job (Imahara, 1993). One study of nurses reveals that differences in language, interpersonal relations, and lifestyles create misunderstandings and conflicts between nurses educated in the Philippines and Anglo-American nurses (Spangler, 1991). Fortunately, acculturation on the part of Filipinos ameliorates these problems, but this is a slow process, one that can be helped along by more training. In general, there is a need for greater understanding and tolerance about different cultures, and more appreciation for the potentially unique contributions of those educated abroad.

Finally, Asian Pacific Americans should have a voice in the operations and decision-making of the public hospitals. While they comprise a disproportionate share of the medical and nursing staff in the public hospitals in the large metropolitan areas, they have not moved into supervisory and management positions in the same proportions. This discrepancy can be seen in detailed employment statistics for the three major public hospitals in Los Angeles. Asian Pacific Americans comprise 34 percent of the professionals (physicians and nurses), 28 percent of supervisory professionals (e.g., Supervising Clinic, Staff or Surgery Nurse, or Senior Physician), but only 12 percent of management positions (Chief Physicians, Directors of Nursing, or Nursing Directors). There is no simple explanation for this discrepancy, but nonetheless, the consequence is a lack of an Asian Pacific perspective in the development of policies, which, in turn, can adversely affect the effectiveness and appropriateness of health care in these facilities.

The Asian Pacific voice is particularly important as we undertake the debate over health care reform. Inadequate health care for the

poor, along with rising costs, is at the heart of the current discussions on the President's proposal for reform. Although some changes will occur, it is likely that we will continue to see unequal access to health care. There will still be those who have less coverage, live in neighborhoods that have few medical resources, and rely on public facilities. There may be new incentives to increase the number of physicians and nurses working in the inner-cities, but it is unlikely that the maldistribution of private-sector professionals will be completely eliminated. Under these conditions, Asian Pacific Americans will continue to constitute a disproportionately large share of the providers on the front-line. Incorporating the concerns and insights of these individuals would help in the planning for whatever new health system emerges.

Notes

1. These and the following national statistics are based on data from the 1990 and 1993 *Economic Report of the President*. The dollar amounts are reported for 1992 dollars, and the 1992 figure is based on the third quarter.
2. Statistics on international comparisons are based on data from the Organization of Economic Cooperation and Development, Department of Health and Human Services, and the data on per capita expenditure and insurance coverage are cited in the White House Domestic Policy Council, 1993, p. 11. The data show that per capita expenditure in the U.S. is approximately twice that in the industrialized countries of Europe and over one-and-a-half times that in Canada.
3. These dismal statistics are the outcome of both larger social and behavioral problems that create health problems and the lack of adequate health care services.
4. The large medical bills of the elderly are not just the consequence of Medicare. The elderly have greater health needs given the illnesses associated with advanced age. Medicare, along with Medicaid for the medically indigent elderly, has allowed this population to secure medical treatment, much of which is very expensive.
5. This program also includes the elderly who are medically indigent, and thus cannot cover the co-payment for Medicare, and the non-elderly disabled. Although children and adults in families accounted for 72 percent of the enrollees in 1990, they received only 29 percent of the dollar benefits (Kaiser Commission on the Future of Medicaid, 1992).
6. This is according to data from the American Medical Association, which are cited by the Kaiser Commission on the Future of Medicaid, 1992.

7. Data on the uninsured is taken from the chapter on "The Economics of Health Care," in *Economic Report of the President*, 1993, and page 137 in particular, from the White House Domestic Policy Council's *Health Security, The President's Report to the American People* (1993), and from Employee Benefit Research Institute (1992). Additional data compiled from the 1992 Current Population Survey by the authors. There are differences in estimates, depending on how the insurance-status of children are determined. Professor E. Richard Brown of UCLA provided valuable comments on using the CPS data; however, we alone are responsible for the compiled statistics.

8. For a family of four, the poverty line in 1991 was $13,924. The poverty line varies by family size and composition.

9. This is based on Hafner-Eaton, 1993. This study also indicates that after controlling for numerous independent variables (e.g., insurance, health, and income status), utilization of health care by Asian Pacific Americans is considerably lower than other racial groups. This may be due to several factors, such as culturally determined health care behavior, and language and cultural barriers.

10. President Carter attempted to regulate hospital expenditures but his plan was rejected by Congress in favor of a voluntary program proposed by the American Hospital Association. The program was initially able to control rising hospital outlays, but it had no lasting effect (Ginzberg, 1993).

11. This facility was Martin Luther King-Drew, which houses the Drew Medical School (Brown, Aneshensel, and Pollack, 1993). Ironically, this hospital was established in response to findings from the McCone Commission's report on the causes of the 1965 Watts riots, which cited the gross inadequacy of health care in the areas affected by the riots. While having this facility in South Central, which includes Watts, represents some improvement, the inability of providing quality care shows a lack of long-term commitment.

12. This is based on median total earnings in 1989 as reported in the 1990 1% Public Use Microdata Sample, which include salaries and self-employment income. The median is used because a large number of physicians have earnings that fall in the top, open-ended income category, thus any estimate of the mean would be seriously biased downward. The estimated median annual earnings for physicians in the four metropolitan regions are $45,000 for those in public hospitals, $60,000 for those in private hospitals, and $121,000 for those in a private, non-hospital setting.

13. This group of four includes the following: New York, Nassau-Suffolk, and Newark Metropolitan Statistical Areas (MSAs); Chicago MSA; Los Angeles, Orange, San Bernardino, and Ventura Counties; and San Francisco, Oakland, and San Jose MSAs. These regions were selected because they contain large numbers of Asian Pacific American health care providers. The statistics are compiled from the 1990 Census 5% Public Use Microdata Sample.

14. Annual earnings and hourly wages are estimated from the 1990 5% Public Use Microdata Samples for the four metropolitan regions. The median annual earnings in 1989 for RNs in public hospitals was higher than that for RNs in private hospitals ($35,000 and $32,000, respectively), but the median hourly wage was slightly lower ($18.00 and $18.13, respectively). Those working in hospitals generally earn more than those working outside hospitals, a pay difference that is associated with the greater stress and poorer working conditions in hospitals.

15. These figures come from the CD-ROM version of the Equal Employment Opportunity (EEO) File compiled from the 1990 Census.

16. The 1970 numbers for Asian Pacific registered nurses and practicing physicians only include figures for the Chinese, Japanese and Filipino population. There were 1,242 Chinese, 2,524 Japanese, and 8,051 Filipino nurses. For practicing physicians, there were 2,632 Chinese, 1,654 Japanese and 5,701 Filipino.

17. *Minorities and Women in the Health Fields*, 1987 Edition, U.S. Department of Health and Human Services, Health Resources and Services Administration; Association of American Medical Colleges, *Minority Students in Medical Education: Facts and Figures*, Volume 6, December 1991.

18. The Public Use Microdata Sample for the 1990 Census does not contain information on place of education. In the case of U.S.-born, we assume that they received their education in this country. Because some may have gone abroad for their medical education, this assumption biases the estimates in favor of the number of U.S.-educated persons. For immigrants, we first calculate the number of U.S.-educated persons by first imputing the age of individuals at the time of entry into the United States, which is equal to age at the time of the Census minus years in the U.S. Because the time of entry into this country is reported as categorical data, we estimate the number of years in this country by taking the mid-point for each categorical period. If we assume the physicians typically complete their medical education by age 24 then we estimate that 36 percent are U.S.-educated. Twelve percent were U.S.-born and 5 percent are immigrants who were 12 years old or younger when they entered the U.S.

19. The method described in the previous footnote is also used to estimate the statistics on nurses. If we assume that nurses typically finish their education by age 21, then 25 percent are U.S.-educated. This is based on the 8 percent who are U.S.-born and 17 percent are immigrants who were 21-years old or younger when they entered the U.S. If we assume that nurses typically complete their education by age 20, then 21 percent are U.S.-educated. Data from the 1988 National Sample Survey of Nurses indicate that 73 percent of Asian nurses received their basic nursing education abroad.

20. During the 1950s, several legislative modifications to the act limited the use of these temporary visas and implemented restrictions on adjustments to permanent status.

21. The FMG numbers include 24,170 U.S. citizens who received their education abroad. However, this can also include naturalized citizens (Roback et al, 1986).

22. This is based on estimates from the Census. Data from the 1988 National Sample Survey of Nurses, by the PHS Division of Nursing, U.S. Department of Health and Human Services, indicate that only 3 percent of the RNs received their basic nursing education abroad. However, it appears that the number of Asian Pacific Americans RNs is undercounted. While 1990 Census data show that over 4 percent of all RNs are Asian Pacific Americans, the Survey of Nurses show that only 2.3 percent (based on the weighted sample) are Asian Pacific American. This discrepancy may be due to ethnic differences in the response rate to the Survey, or to a difference in definitions of RNs used by the Census and the Survey. The Census relies on self-reporting while the Survey relies on listing of those with licenses to practice.

23. In the 1988 National Sample Survey of Nurses, 72 percent of the Asian-educated respondents were from the Philippines.

24. The relative overrepresentation is not limited to the large metropolitan areas. This is due in part to the maldistribution of all doctors and nurses, which leaves both the inner-cities and small towns underserved. On the other hand, FMGs are more evenly distributed throughout the country (U.S. Department of Health and Human Services, 1983). One consequence is that foreign-medical graduates are relatively more likely to be found in non-metropolitan areas because some of these communities have turned to immigrant doctors. A recent study reports that an estimated 75 percent of physicians in rural Michigan are immigrants, and that about half of Illinois' 12,000 immigrant doctors have their practice outside the cities and suburbs (Johnson, 1993). In the small town of Dixon, Illinois, the hospital is staffed by doctors from China, Korea, and India.

25. Prepared statement of Stephen H. Cooper, VP, Hospital Association of New York State before the House of Representatives at the Hearing on H.R. 1507 and H.R. 2111, Immigration Nursing and Relief Act of 1989, on May 31, 1989.

26. Testimony of Irene McEachen, VP, Nursing, Beth Israel Medical Center in New York City before the House of Representatives at the Hearing on H.R. 1507 and H.R. 2111, Immigration Nursing and Relief Act of 1989, on May 31, 1989.

27. Testimony of Katherine Abelson, Exec. VP, Local 1199 Drug, Hospital and Health Care Employees Union/RWDSU/AFL-CIO before the House of Representatives at the Hearing on H.R. 1507 and H.R. 2111, Immigration Nursing and Relief Act of 1989, on May 31, 1989.

28. Prepared statement of Stephen H. Cooper, VP, Hospital Association of New York State before the House of Representatives at the Hearing on H.R. 1507 and H.R. 2111, Immigration Nursing and Relief Act of 1989, on May 31, 1989.

29. Prepared statement of Stephen H. Cooper, VP, Hospital Association of New York State before the House of Representatives at the Hearing on H.R. 1507 and H.R. 2111, Immigration Nursing and Relief Act of 1989, on May 31, 1989.

30. Place of intended residence is reported by zip code. We used the following three-digit codes to define our areas: 070 to 073 and 100 to 116 (New York/Newark); 600 to 606 (Chicago); 940 to 949 (San Francisco/Oakland); and 900 to 918 (Los Angeles).

31. The total is based on unpublished data provided by the Equal Employment Opportunity Commission. Percentages are for Los Angeles-Anaheim-Riverside CMSA, San Francisco-Oakland CMSA, New York, New Jersey and Connecticut CMSA, and the Chicago(IL)-Gary(IN)-Lake County(WI) CMSA. Unless otherwise noted, statistics included in this paragraph are drawn from this source.

32. As a comparison, the 1990 Census shows that Asian Pacific Americans comprised no more than 15 percent of the population in these four metro areas (9 percent in Los Angeles, 15 percent in San Francisco, 3 percent in Chicago, and 6 percent in New York).

33. Using the method described earlier, we estimate from the 1990 Census that 44 percent of the physicians and 21 percent of the nurses in the four metropolitan region are U.S.-educated.

34. The statistics are compiled from data provided by Professor Tom Larsen of California State University, Los Angeles.