


# From imperialism to inpatient care: Work differences of Filipino and White registered nurses in the United States and implications for COVID-19 through an intersectional lens

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## Abstract

In the United States, nursing is the largest healthcare profession, with over 3.2 million registered nurses (RNs) nationwide and comprised of mostly women. Foreign-trained RNs make up 15 percent of the RN workforce. For over half a century, the U.S. healthcare industry has recruited these RNs in response to nurse shortages in hospitals and nursing homes. Philippines-trained RNs make up 1 out of 20 RNs in this country and continue to be the largest group of foreign-trained nurses today. Recently, the news media has publicized the many deaths of Filipino RNs as a result of the COVID-19 pandemic in the United States. Given the imperial historical ties between these two countries in the context of the nursing profession and the enduring labor inequities that persist, this nationally representative study is one of the few to our knowledge to not only quantitatively examine the current work differences in characteristics and experiences of Philippines-trained RNs and U.S.-trained white RNs practicing in the United States today, but to also do so from an intersectionality lens. The overall aim of this paper is to illuminate how these differences may serve as potential factors contributing to the disproportionate number of Filipino nurses' COVID-19 related vulnerability and deaths in the workplace.

**KEYWORDS**

COVID-19, Filipino nurses, imperialism, intersectionality, United States

## 1 | INTRODUCTION

In recent months, the news media and memorial websites have publicized the many deaths of frontline Filipino registered nurses (RNs) as a result of the COVID-19 pandemic in the United States (Enano, 2020; Martin & Yeung, 2020; Pasay-an, 2020; The Staffs of KHN and The Guardian, 2020; AF3IRM Transnational Feminist Organization). Prior Research has even indicated that in the 1980s and 1990s many immigrant Filipino RNs ended up in hard to recruit healthcare settings including rural and inner-city hospitals and worked on the frontlines of the AIDS epidemic and outbreaks of SARS and Ebola (Martin & Yeung, 2020; Phua et al., 2005; Sagar, 2015). Yet, little attention has been paid to the work characteristics and experiences of these RNs once they arrive to this country; critically analyzing these aspects, including the different settings and positions where these nurses work, can lead to a more thorough understanding of the impacts of structures channeling foreign-trained nurses into U.S.-based roles (Apellido, 2018; Hayne et al., 2009; Jurado & Saria, 2018).

Nursing is the country's largest healthcare profession, with between 3.2 to 3.8 million RNs nationwide and mostly comprised of women (U.S. Bureau of Labor Statistics, 2019; American Association of Colleges of Nursing, 2019a). RNs play a vital role in the public health response to pandemics and epidemics, delivering direct patient care and risk exposure to communicable diseases, occupational hazards, burnout and stressful working environments (Dalziel, 2003; Fernandez et al., 2020; Imai et al., 2004; Lee & Wang, 2002).

15 percent of the RN workforce are foreign-trained (Hohn et al., 2016). Prior quantitative studies have paid closer attention to concerns on how foreign-trained RNs affect the quality of patient care, the negative impact on the labor market opportunities of U.S.-trained RNs, and the supply of RNs in the sending countries (Aiken et al., 2001; Blakeney, 2006; Brush et al., 2004; Flynn & Aiken, 2002; Germack et al., 2017; Glaessel-Brown, 1998; Kaestner & Kaushal, 2012; Lovell, 2006; Polsky et al., 2007; Trucios-Haynes, 2002; United States, 1989). Much of this work rarely contextualizes the imperial history between sending and receiving countries such as the Philippines and the U.S., intersected with the differences in work characteristics and experiences between foreign-trained and U.S.-trained nurses.

### 1.1 | Most immigrant healthcare workers in the U.S. are from the Philippines

In *Empire of Care*, the first book-length study of the history of Filipino nurses in the United States, Choy (2003) asserts that the initiation of Filipino nurse migration dates all the way back to the American imperialism of the Philippines (1898–1946) that included bringing in westernized ideals into government, education and healthcare. Although intended to prepare Filipinos for Philippine self-government, U.S. colonial policies inadvertently prepared Filipino RNs to work in the United States. More specifically these trainings created preconditions (e.g., Americanized nursing curriculum, fluency in the English language) for their recruitment to alleviate U.S. nursing shortages in hospitals and nursing homes. Historically and today, the leading destination for Filipino nurse migrants has been the United States (Hohn et al., 2016). Out of the top 5 countries of origin for foreign-born RNs, Philippines leads at 33%, followed by India (6%), Jamaica (5%), Canada (4%) and Nigeria (4%) (Hohn et al., 2016). Overall, 357,300 Filipino immigrants are working in the U.S. healthcare system today (U.S. Census Bureau, 2019b). Of this number, approximately 143,000 (4.5%) of them are Filipino immigrant RNs, making the Philippines still the largest supplier of foreign-born RNs in the United States (U.S. Census Bureau, 2019b). Together, Filipino immigrants make up approximately 1 out of 20 RNs in this country (New American Economy Research Fund, 2020; U.S. Census Bureau, 2019b).

Recently, a report by the National Nurses United (NNU) (2020) union (the largest union and professional association of RNs in the United States) found that racial/ethnic minority nurses, specifically Filipino RNs are disproportionately dying of COVID-19 compared to white RNs. NNU claims that there has been widespread resistance on the part of the U.S. healthcare industry to transparently provide information on nurse and other healthcare worker COVID-19 related fatalities. Thus far, they have been able to confirm 213 COVID-19 related deaths by using media reports, social media, obituaries, union memorials, and some federal and state reporting. Of this number, 31.5% were of Filipino descent and 39.4% were white. However, Filipino RNs make up only 4.5% (U.S. Census Bureau, 2019b) of the RN workforce in the United States while whites make up 75.9% (U.S. Bureau of Labor Statistics, 2019). Amongst all RNs of color, they found that Filipinos are the largest non-white ethnic group to die of this pandemic, followed by Black (17.8%) and Latinx (6.6%) RNs.

Given the imperial historical ties between the Philippines and the United States and the disturbing reports of the recent COVID-19 related deaths of Filipino nurses, the goal of this paper is to quantitatively examine the current work differences in characteristics including demographics, settings and experiences of Philippines-trained RNs and U.S.-trained white RNs practicing in the United States today. In order to better understand these differences, we also utilize an intersectionality theoretical framework which posits that the multiple social categories and systems (e.g., gender, race/ethnicity, socioeconomic status, imperialism and other forms of power) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (Choo & Ferree, 2010; Collins & Patricia, 2002). Moreover, intersectionality analysis focuses on power dynamics as relational and comparative in the workplace (Tomaskovic-Devey, 2014).

Public health scholars have increasingly emphasized the importance of utilizing this framework for investigating inequalities found in health and healthcare (Bowleg, 2012; Caiola et al., 2014; Hankivsky et al., 2014; Heard et al., 2020). McCall (2005) asserts that intersectional approaches may be most optimal when scholars across a variety of disciplines take part in collaborative Research efforts. Hence, as a multidisciplinary team consisting of a historian, medical sociologist, and public health quantitative and qualitative researchers, we aim to illuminate the intersections of individual's multiple identities within social systems of power that compound and exacerbate different work experiences in the healthcare setting and highlight how these differences may serve as potential factors contributing to the disproportionate vulnerability and deaths of Filipino nurses due to COVID-19 today.

## 2 | LITERATURE REVIEW

### 2.1 | Historical imperial ties between Filipino and white women RNs

Intersecting colonial and imperial histories, scholars underscored how these policies have driven the flow of resources, including healthcare workers, from the global South to the U.S. and other global North countries (Sefa Dei & Asgharzadeh, 2002) and determined what and who is prioritized in public health, impacted the nature of global health intervention (e.g., vertical health campaigns, top-down approaches), and emphasized western science (Kim et al., 2017). Transnational feminist writings expose the historical roots of imperialism, occupation and subjugation that have structurally shaped the lives of millions of Filipinos scattered around the world today (Espiritu, 2003).

Choy (2003) draws particular attention to white American women's participation in the U.S. colonization of the Philippines and argues that the scant attention paid to the roles these women play will continue to erase America's imperial past in general and contests this erasure by highlighting white American women's narratives and subjectivity during this time. In 1907, white American women spearheaded the establishment of the first U.S. government supported professional nursing schools and training programs in the Philippines. U.S. constructed knowledges compared nursing education to missionary work and the teaching and refining of "little brown sisters" (Choy, 2003, p. 35). These socially constructed power inequities between women and inferior views of Filipino women played a critical role in creating the formation of American modernity, specifically in American women's

construction of themselves as civilized women providing superior quality care and creating employment disparities between these two groups of RNs (Newman, 1999; Rafael, 2000; Wexler, 2000). This process of marking “other” ethnic groups and essentializing ethnic differences and stereotypes has led to the obscurity of social, economic and power relations that are continually gendered and racialized (Ahmad & Bradby, 2007).

We see these dynamics play out even after the Philippines became a sovereign country. For example, researchers documented particular cases where recruited Filipino exchange visitors served as a cheaper labor force and experienced work exploitation (e.g., less desirable work shifts, underemployment, lower wages compared to their white American nurse counterparts) while filling the frequent shortage of medical personnel in the U.S. healthcare industry (Alinea & Senador, 1973; Capulong, 1965). They also reported xenophobic sentiments expressed by American RNs, including a commission of the American Nurse Association, that in turn transformed Filipino RNs from a welcome exchange visitor and immigrant into an alleged threat to the U.S. healthcare system (Choy, 2003).

## 2.2 | Contemporary works related to Philippines-Trained nurses

Other social scientists have since documented the enduring global inequities between higher-income (global North) and lower-income (global South) countries that continue to prompt migration and the micro-level indignities that Filipino care workers have endured in their host countries (Cranford, 2020; Francisco-Menchavez, 2018). Notably, structural and policy influences on the nursing profession eventually did not happen unilaterally and would contribute to the ongoing push-pull factors experienced by immigrant Filipino RNs. Case in point, while the 1965 Immigration and Nationality Act that implemented a preference system that concentrated on immigrants' technical skills and family reunifications with U.S. citizens or residents (Chishti et al., 2015), then President Ferdinand Marcos also shifted the Philippines government's commitment to a labor export-oriented economy in the 1970s (O'Neil, 2004). The Philippines government began aggressively promoting the outmigration of Filipino RNs, touting them as new national heroes for the billions they remit annually in foreign currency (Rodriguez, 2010). Moreover, the devaluation of the Philippine peso against the U.S. dollar made the United States a highly attractive destination. These structural policies combined with recruiting agencies in both the United States and the Philippines would continue to shape the contemporary experiences of Philippines-trained RNs (U.S. Department of Health and Human Services, 2002; Brush et al., 2004; Guevarra, 2009; Spetz, 2014).

Parreñas (2000) and Hochschild (2000) developed the “international division of reproductive labor” and the “global care chains” concepts that exposed one of the consequences related to the exportation and transfer of gendered and racialized labor with precarious citizenship status that linked domestic work, migration and globalization. Both concepts underscore the unfair distribution of this labor that is increasingly imposed on lower income, immigrant women in a globalized economy (Todaro & Arriagada, 2020).

Guevarra (2009) exposed the roles of Philippine-based labor brokers and recruiting agencies marketing Filipino women as inherently more suitable for providing care work around the world and actually selling *Filipinas* as a trademarked labor. Their “added export value” further emphasized a gendered and racialized form of labor power used to construct Filipino nurses and domestic workers as *ideal*, *superior* and *better* than other workers from different ethnic groups. Such constructs in turn absolved white women of these racialized stereotypes while pitting women of color against each other.

Nazareno (2018) found that Filipinos had used their nursing background acumen and gendered constructs as ideal healthcare workers to develop businesses in the U.S. long-term care industry. This Research highlighted the racialized logic of larger market forces that shaped the entry and subsequent experiences of discrimination amongst immigrant Filipino nurses who established businesses in the second-tier, marginalized sectors of the U.S. long term care industry. Altogether, these contemporary works have drawn from the imperial past between the Philippines and the United States and its subsequent consequences including the intersection of gender, race, class, citizenship status, and power inequalities between women in the nursing labor force. This overlaid with the

alarming number of reports related to the recent deaths of Filipino RNs due to COVID-19 heightens the importance of understanding and addressing the differences in demographics; employment characteristics and work experiences compared and in relation to white RNs; particularly when in the United States, this pandemic disproportionately impacts racial ethnic minorities (Tai et al., 2020).

### 3 | METHODS

Scholars contend that intersectionality approaches are often not viewed as associated to traditional biomedical, quantitative, variable-oriented, methodologies such as multivariate, predictive models and more often associated with traditional, qualitative methodological approaches such as ethnography or case studies (Mullings & Schulz, 2006). Instead of these narrowly dichotomous biomedical versus an intersectional paradigm and quantitative versus qualitative perspective, Kelly (2009:E46) advocates that "the integration of feminist intersectionality and biomedical paradigm in research occurs in the selection of the research problems, design, and methods, and in the operationalization of the assumptions of each paradigm throughout the research process." The integration of the intersectional and biomedical paradigm requires an orientation toward the data, no matter the methodology with which it is collected, such that questions related to socially constructed categories of difference, power differentials, and mutually constituted social identities are considered (Caiola et al., 2014).

Hence, beyond utilizing quantitative methods to explain the relationship between independent and dependent variables, we use an intersectional lens to illuminate the embedded historical and social context and associated power relations in order to help explain why these labor relationships between white and Filipino RNs in healthcare delivery remain interconnected.

This study conducted secondary analyses using data from the 2018 National Sample Survey of RNs (NSSRN). The 2018 NSSRN is a cross-sectional survey of U.S. Registered nurses (RNs) and nurse practitioners (NPs) designed to estimate characteristics of RNs and NPs in the workforce by state and nationally, including basic demographics and background information, education, nursing employment, and license and certification details (U.S. Department of Health and Human Services, Health Resources and Services Administration, & National Center for Health Workforce Analysis, 2019). The NSSRN is particularly suited for the purposes of these analyses, given its national coverage, detailed examination of nurse's work experiences and conditions, and inclusion of variables that allow users to identify nurses who were trained in the Philippines.

Detailed methods of the 2018 NSSRN have been discussed elsewhere (U.S. Department of Health and Human Services et al., 2019). RNs, stratified by licensing state and then NP license, were randomly sampled from licensure records provided by the National Council of State Boards of Nursing (NCSBN) and individual state nursing boards. Appropriate sampling rates were used for each state to produce reliable estimates of RNs and NPs at the state level. The 2018 NSSRN includes 50,273 participants, with an unweighted response rate of 50.1% (49.1% weighted).

#### 3.1 | Measures

**Independent variable.** The independent variable of interest was country of nursing training, with the Philippines versus the United States. Participants were coded as Philippines- or U.S.-trained via self-report. Country of training was further distilled for race for U.S.-trained RNs based on self-report. The independent variable included two categories: Philippines-trained RNs and white U.S.-trained RNs.

**Employment and work setting variables.** Characteristics of employment and work settings included: full-time primary nursing position status, secondary employment status, health position employment prior to RN, type of work, and work setting. Full-time primary nursing position was dichotomized as having a full-time position or not

having a full-time position. Secondary employment was dichotomized as having secondary employment or not having secondary employment. Employment in health position prior to RN was categorized as nursing aide, home health aide, practical/vocational nurse, community health worker, and other. Work setting was coded as hospital, other inpatient setting, ambulatory or clinic, and other.

Type of work was defined as acute in-patient; long-term in-patient care; indirect, outpatient, or non-acute; and other. Respondents were considered to work in acute, in-patient care if they indicated their primary position was one of the following: general or specialty inpatient, critical care, emergency, sub-acute care, surgery, urgent care, or step-down, transitional, progressive telemetry. Long-term in-patient care consisted of respondents indicating their work was in long-term care or a nursing home. Indirect, outpatient, or non-acute care included the following: ambulatory care, ancillary care, care coordination, education, healthcare management administration, informatics, public health/community health, rehabilitation, research, school nurse, or home health/hospice.

**Work experiences variables.** Dependent variables included characteristics of work experiences. Satisfaction with current nursing position was coded as satisfied with current position or dissatisfied with current position. Practicing nursing to extent of knowledge was dichotomized as yes or no. Consideration to leave their primary nursing position was categorized as have considered leaving their position and have not considered leaving. For those who considered leaving, reasons for considering leaving were answered with yes or no and included: lack of advancement opportunities, burnout, interpersonal differences with colleagues or supervisors, and stressful work environment. While other reasons for considering leaving were included in the 2018 NSSRN (e.g., change in child's school, length of commute, physical demands), the reasons included in this study were considered to be potential indicators of differential treatment for Philippines-trained versus white U.S.-trained participants. Whether a participant left their primary nursing position in the past year was categorized as yes or no. For those who left their position, reasons for leaving were the same as those for reasons for considering leaving and were responded to as yes or no.

**Demographic variables.** The following sociodemographic variables were included: age, sex, educational level, years since graduating from initial RN program, marital status, household income, geographical location, having dependents, and labor union or collective bargaining unit membership status. Age in years of participants were categorized as follows: 49 or younger, 50–64, and 65 and older. Sex included female and male. Educational level was dichotomized as having a bachelor's degree and below or a master's degree and above. Years since graduating from initial RN program was categorized as 3 years or sooner, 4–55 years, and 56 years or more, a default grouping incorporated into NSSRN to identify proportions of RNs at the extremes (e.g., novice and extremely experienced RNs). Marital status was defined as married/in a domestic partnership. Household income was coded as \$50,000 or less, \$50,001 to \$100,000, and more than \$100,000. Geographical location included: California, Florida, Illinois, New York, New Jersey, Texas, and other, a grouping largely chosen based on substantial populations of Filipino immigrants to identify differences in geographical concentration (U.S. Census Bureau, 2019a). Having dependents was defined as having children (up to age 18) at home, adults at home, others not at home, and no dependents. Membership to a labor union or collective bargaining unit was dichotomized as yes or no.

### 3.2 | Data analysis

Weighted proportions and  $\chi^2$  tests were computed to summarize and compare demographic variables, characteristics of employment and work settings, and characteristics of work experiences for Philippines-trained and white U.S.-trained participants. Multivariable logistic regressions were performed to determine associations between our independent variable (i.e., Philippines-trained participant and white U.S.-trained participants) and the following work experience outcomes: satisfaction with current position, practicing to the extent of their knowledge, considering leaving their primary nursing position, reasons to consider leaving primary nursing position, leaving

TABLE 1 Weighted demographics for Philippines-Trained nurses and white US-Trained nurses, 2018 NSSRN

	Philippines-Trained (N = 827)	White US-Trained (N = 41,444)	p-value
Age			
49 or younger	55.7%	49.4%	0.12
50–64	31.9%	35.2%	
65+	12.4%	15.4%	
Female	84.3%	91.3%	<0.01*
Masters or higher	8.7%	19.9%	<0.01*
Years since graduating			
3 years or sooner	1.7%	7.3%	0.01*
4–55 years	97.8%	91.9%	
56 years or more	0.5%	0.9%	
Married	77.2%	73.4%	0.17
Household income			
\$50,000 or less	6.7%	9.4%	0.02*
\$50,001 to \$100,000	33.0%	39.5%	
More than \$100,000	60.4%	51.1%	
Geographical location			
California	38.8%	5.5%	<0.01*
Florida	5.6%	5.7%	
Illinois	6.6%	4.0%	
New York	7.8%	5.4%	
New Jersey	7.7%	2.2%	
Texas	8.4%	5.3%	
Other	25.1%	71.9%	
Dependents			
Children (up to age 18) at home	39.2%	38.8%	0.91
Adults at home	33.5%	16.1%	<0.01*
Others not at home	12.3%	14.1%	0.43
None	29.6%	41.6%	<0.01*
Member of labor union or collective bargaining unit	30.5%	13.8%	<0.01*

\* $p < 0.05$ .

primary nursing position in the past year, and reasons for leaving. Regression models controlled for age, time since graduation, educational level, marital status, and sex. We utilized a two-tailed test ( $p < 0.05$ ) to determine statistical significance, and present adjusted odds ratios and 95% confidence intervals (CIs). To account for complex survey design, all analyses used sample weights to approximate the results to the target population. Statistical analyses were conducted using Stata version 15 (StataCorp, 2017).

**TABLE 2** Weighted characteristics of employment and work settings for Philippines-Trained nurses and white US-Trained nurses, 2018 NSSRN

	Philippines-Trained (N = 827)	White US-Trained (N = 41,444)	p-value
Has full-time primary nursing position	86.5%	77.7%	0.01*
Has secondary employment	13.8%	10.0%	0.08
Employment in health position prior to RN			
Nursing home aide	9.4%	48.2%	<0.01*
Home health aide	1.5%	6.3%	<0.01*
Practical/Vocational nurse	15.6%	12.5%	0.22
Community health worker	0.1%	0.8%	0.05*
Other	8.2%	19.5%	<0.01*
Type of work			
Acute in-patient	49.6%	41.5%	0.01*
Long-term in-patient care	7.3%	3.0%	<0.01*
Indirect, outpatient, or non-acute	22.5%	34.5%	<0.01*
Other	1.5%	1.7%	0.83
Work setting			
Hospital	53.6%	48.7%	0.14
Other inpatient setting	12.6%	6.4%	<0.01*
Ambulatory or clinic	7.2%	13.5%	0.03*
Other	11.2%	13.2%	0.47

\* $p < 0.05$ .

### 3.3 | Findings

Weighted sample sociodemographic data are presented in Table 1. A higher proportion of Philippines-trained RNs had household incomes over \$100,000, though nearly 40% of Philippines-trained RNs reside in California, whereas white U.S.-trained RNs had a more even geographical spread. There was a higher proportion of Philippines-trained RNs with dependents who were adults living in their home compared to white U.S.-trained RNs, who more frequently reported having no dependents. A higher proportion of Philippines-trained RNs also reported being part of a labor union or collective bargaining unit than their white U.S.-trained counterparts. A higher proportion of Philippines-trained RNs were males compared to white US-trained RNs. Significant differences were also observed years since graduating.

Weighted characteristics of employment and work settings are presented in Table 2. A higher proportion of Philippines-trained RNs had full-time primary nursing positions than white U.S.-trained RNs. More U.S.-trained white RNs reported working as nursing aides, home health aides, community health workers, or in some other health position prior to becoming an RN than their Philippines-trained counterparts. Philippines-trained RNs reported working more frequently in acute, in-patient and long-term in-patient care roles, and reported working less frequently in indirect, outpatient, or non-acute roles compared to their white U.S.-trained colleagues. A higher proportion of Philippines-trained RNs also reported working in inpatient settings other than a hospital than their



**TABLE 3** Weighted characteristics of work experiences for Philippines-Trained nurses and white US-Trained nurses, 2018 NSSRN

	Philippines-Trained (N = 827)	White US-Trained (N = 41,444)	p-value
Satisfied with current position	90.1%	89.2%	0.73
Practicing to extent of knowledge	92.3%	76.4%	<0.01*
Considered leaving primary nursing position	27.8%	56.2%	<0.01*
Reasons to consider leaving			
Advancement opportunities	30.1%	18.3%	0.05*
Burnout	59.4%	43.6%	0.03*
Interpersonal differences	23.7%	15.8%	0.17
Stressful work environment	44.6%	41.3%	0.66
Left primary nursing position in the past year	7.4%	12.8%	0.03*
Reasons for leaving			
Advancement opportunities	4.1%	14.9%	0.02*
Burnout	23.0%	31.0%	0.47
Interpersonal differences	6.1%	14.4%	0.17
Stressful work environment	24.8%	33.0%	0.48

\* $p < 0.05$ .

white U.S.-trained counterparts, while a lower proportion of Philippines-trained RNs reporting working in an ambulatory or clinic setting.

Weighted characteristics of work experiences are presented in Table 3. More Philippines-trained RNs indicated that they were practicing to the extent of their knowledge. While white U.S.-trained RNs reported that had considered actually leaving their primary nursing position in the past year at a rate double that of the Philippines-trained RNs, more Philippines-trained RNs reported that lack of advancement opportunities and burnout were reasons to consider leaving their position compared to white U.S.-trained RNs. White U.S.-trained RNs reported leaving a primary nursing position in the past year at a higher rate than Philippines-trained RNs, with a higher proportion of white U.S.-trained RNs reporting leaving over advancement opportunities compared to Philippines-trained RNs.

### 3.4 | Multivariable logistic regression

After controlling for age, time since graduation, educational level, marital status, and sex, the odds of practicing to the extent of their knowledge was highly associated with Philippines-trained RNs compared to U.S.-trained RNs presented in Table 4 (OR = 3.72; 95% CI = 2.26–6.13;  $p < 0.01$ ). Philippines-trained RNs also reported lower odds of considering leaving their primary nursing position in the past year (OR = 0.30; 95% CI = 0.22–0.41;  $p \leq 0.01$ ), though they reported higher odds of considering leaving due to burnout (OR = 1.83; 95% CI = 1.02–3.29;  $p = 0.04$ ). Philippines-trained RNs reported higher odds of considering leaving due to lack of advancement opportunities, however, this association was marginally significant (OR = 1.96; 95% CI = 0.98–3.92;  $p = 0.06$ ).

**TABLE 4** Adjusted odds ratios for work settings and experiences for Philippines-Trained nurses with white US-Trained nurses as referent, 2018 NSSRN

	Philippines-Trained (95% CI)
Satisfied with current position	1.10 (0.61–2.00)
Practicing to extent of knowledge	3.72 (2.26–6.13)*
Considered leaving primary nursing position	0.30 (0.22–0.41)*
Reasons to consider leaving	
Lack of advancement opportunities	1.96 (0.98–3.92)
Burnout	1.83 (1.02–3.29)*
Interpersonal differences	1.65 (0.77–3.56)
Stressful work environment	1.19 (0.64–2.18)
Left primary nursing position in the past year	0.56 (0.31–1.01)
Reasons for leaving	
Lack of advancement opportunities	0.22 (0.04–1.19)
Burnout	0.62 (0.17–2.26)
Interpersonal differences	0.39 (0.05–3.05)
Stressful work environment	0.67 (0.19–2.41)

\* $p < 0.05$ .

## 4 | DISCUSSION USING AN INTERSECTIONALITY LENS

For decades and into current day, Filipino scholars and various news media outlets have attempted to highlight the contributions of Philippines-trained registered RNs in the United States that often go under-appreciated and unrecognized (Choy, 2003, 2019; Guevarra, 2009; Martin & Yeung, 2020; McFarling, 2020; McLaughlin, 2020). This nationally representative study provides insight into the nature and magnitude of contemporary work-related differences between these two groups, and is one of the few to our knowledge to not only quantitatively examine the current work differences in characteristics and experiences, but to do so from an intersectionality lens as well.

### 4.1 | Demographics

Women made up the majority of RNs in both groups, however we found that a smaller proportion of Philippines-trained RNs are women compared to their white counterparts. Elting (2015) found that a high cultural value placed on family and community fostered a caring ethic in the Filipino culture in general and thus rejecting feminine stereotypes of nurses. Nevertheless, it is important to contextualize our findings given nursing has historically been a gendered profession and is still mostly comprised of women. Intersectionality theory emphasizes placing marginalized women at the center of analysis and that their standpoint is not only located at the intersection of multiple axes of oppression, but also of resistance (Collins, 2002). Stemming from Black feminist thought, Collins' (1990) intersectional analysis stresses a "both/and thinking", that rejects rigid either/or thinking that regards individuals or groups as statically either oppressors or oppressed. Instead, we must account for spaces of resistance and agency within a global matrix of oppressive systems.

As discussed earlier, U.S. political and healthcare leadership historically pushed constructions of Filipino women nurses as an alleged threat to the U.S. healthcare system and previous scholars have stressed quality of care concerns as well as issues related to the labor market in both in the U.S. and sending countries. Yet, our findings related to Philippines-trained RNs today as more likely to be part of a labor union or collective bargaining unit complicates these prevalent narratives. This finding related to forms of resistance via unionization is supported by prior work that highlighted the decades of Filipino nurse activism in the United States (Choy, 2003). By the late 1970s, the confluence of exploitative recruitment practices by agencies both in the United States and the Philippines, controversial licensing examinations and growing awareness of misleading advertisements, low wages, and meager working conditions motivated Filipino RNs to organize and form the Philippine Nurse Association of America, the National Alliance for Fair Licensure of Foreign Nurse Graduates, and the Foreign Nurse Defense Fund (Choy, 2003). Today, Filipino RNs are also members of the National Nurses United (NNU) and one of their current co-presidents, Zenei Cortez, is a Philippines-trained RN who has worked as an RN in the United States for approximately 40 years (National Nurses United, n.d.-a). Hence, in addition to supporting their Filipino family and extended relatives, Philippines-trained RNs are also collectively advocating for the rights of all union-based RNs in the United States in general.

When intersecting our findings related to socioeconomic status, we also found that a higher proportion of Philippines-trained RNs reported having higher household incomes in relation to U.S.-trained white RNs. At face value, this finding potentially points to some level of progress in relation to historical accounts and more recent accounts of labor inequities based on gendered, racialized, and xenophobic notions (Alinea & Senador, 1973; Capulong, 1965; Choy, 2003; Guevarra, 2009; Martin & Yeung, 2020; Nazareno, 2018; Phua et al., 2005; Sagar, 2015). There are two key contextualizations needed in order to appropriately understand these household income findings, however. Firstly, we found that a large proportion of Filipino RNs surveyed work in California, a state with one of the highest costs of living (taxes, food, housing, childcare) compared to other states (The Council for Community and Economic Research, 2018). In the 2014–2018 period, immigrants from the Philippines were highly concentrated in California and was home to 43 percent of the Filipino population (Gallardo & Batalova, 2020). On average, RNs in California earn \$100,000 a year (U.S. Bureau of Labor Statistics, 2020a).

Secondly, we also found that Philippines-trained RNs are disproportionately caring for adult dependents (e.g., aging parents), compared to white U.S.-trained RNs. This finding confirms previous research that immigrant Filipinos are more likely to live in larger, multigenerational households than non-Hispanic whites (Lofquist, 2012; López et al., 2017). Within their home environment, members may also be adding to the household income that may account for the earning differences between these two groups. Moreover, immigrant Filipino women RN not only support their nuclear family but also provide for extended relatives including first and second cousins (Marcus et al., 2014). It is also important to point out that families and extended relatives of these Filipino RNs made the initial investment of using much of their earnings to send their loved one to attain nursing school training-based in the Philippines (Ortiga, 2018). Once abroad, a portion of these foreign-trained RN's incomes are also then used to remit support back to family and relatives. Such transnational remittances are a hallmark of the nurse migration phenomenon and highlights the fiscal sacrifices made on both sides of the ocean in the hope of securing a better future in the United States and the Philippines (Guevarra, 2009). Hence, Filipino RNs are not only disproportionately living in one of the most expensive states in the country, but their wages may be providing support to a higher number of dependents both in their U.S. household as well as in their home country, that in turn leads to less savings and actual net income. In fact, remittances account for 10 percent of the Philippines' GDP (The World Bank, 2019).

## 4.2 | Work experiences

The majority of both Philippines-trained and white U.S.-trained RNs have full-time primary nursing positions. This revelation further supports our findings related to income and job security and may allude to both groups not

having to work multiple employments to meet their socioeconomic needs. Philippines trained RNs appear to be practicing to the extent of their knowledge, hence possibly pointing to progress toward not being underemployed, compared to historical accounts of gendered, racialized, and xenophobic exploitation.

Yet, interestingly, unlike the Filipinos surveyed, whites are less likely to practice to the extent of their knowledge despite more likely having prior work experience in a healthcare setting before becoming an RN and attaining an advanced degree (master's or higher). This finding can potentially be linked to recent findings that show that approximately 57% of newly U.S.-trained licensed RNs leave their jobs within the first 2 years (Wofford, 2019). An earlier study found that 13% of newly licensed RNs had changed principal jobs after one year, and 37% reported that they felt ready to change jobs (Kovner et al., 2007). Nurse turnover rates, particularly in hospitals and nursing homes, are high and more nurses are opting to work in jobs outside of these settings and in nonclinical roles (Aiken, 2007).

According to the American Association of Colleges of Nursing (2019b), one major factor that may be contributing to this exodus is insufficient staffing, raising the stress level of RNs, impacting job satisfaction, and driving many RNs to leave the profession. In line with this prior research, we found that white U.S.-trained RNs disproportionately considered leaving and actually left their primary nursing position in the past year due to burnout. Over 40% of whites also claimed that stressful work environment as a reason for why they considered leaving. This may also help explain why we found that Philippines-trained RNs are more likely to provide both acute or long-term in-patient care and work in in-patient work settings, while whites were more likely to provide indirect, outpatient or non-acute care in ambulatory or clinic settings.

These outpatient settings where white U.S.-trained nurses are working in are characterized to be less stressful work environments with unvarying business operating hours (Barker & Nussbaum, 2011). Whereas, Filipinos are disproportionately laboring in inpatient 24/7 settings such as the ICU and are caring for patients with higher acuity illnesses. Compared to outpatient settings, these work environments are characterized by less desirable and less predictable work hours that can entail various shifts (e.g., holiday, evening, overnight, weekend) and on-call hours (Rogers et al., 2004).

The earlier mentioned finding that a higher proportion of Philippines-trained RNs are part of a labor union and collective bargaining unit may also signal that they are more likely to work in the public sector compared to their counterparts. Union membership rate of public-sector workers (33.6 percent) is more than five times higher than the rate of private-sector workers (6.2 percent) (U.S. Bureau of Labor Statistics, 2020b). These work settings are comprised of federal, state and locally government-funded public hospital systems, community health centers and clinics that make up part of the U.S. safety net and predominantly cater to some of the most vulnerable populations in the United States including those on Medicaid and the uninsured (Institute of Medicine, 2003). Individuals seeking acute care treatment in these spaces are most often disproportionately from racial/ethnic minority backgrounds, have lower income individuals and more likely to have higher rates of chronic conditions and physical limitations compared to higher-income individuals (Khullar & Chokski, 2018). Hence, these racially segmented work environments may carry a higher level of stress because of patients' complex health conditions exacerbated by socioeconomic factors. Moreover, these public sector, union supported jobs also tend to be viewed as lower social status jobs compared to those positions found in the private sector (Lyons et al., 2006; Volcker & National Commission on the Public Service, 1989).

In further comparing and providing a relational analysis of these labor relations between these two groups, it is worth noting that compared to whites, a larger proportion of Filipinos reported burnout as a reason for considering leaving their job. Similarly, more Filipino RNs than whites mentioned a stressful work environment as another reason. Yet, Filipinos were less likely to actually leave their nursing position in the past year, pointing to the persistence of racialized and gendered labor inequities. If they did leave, a smaller proportion of them left for advancement opportunities compared to whites.

Stemming from Piore (1979) work around U.S. labor markets in relation to how social status and prestige contributes to its segmentation, he asserts that immigrants are more willing to take these positions because they

are target earners. Accordingly, they are not as concerned with prestige, but more focused on earning money to purchase a home, consumer goods and investing in education for their family. This could also illuminate why a smaller proportion of Filipinos consider leaving their primary nursing position. Given the pressures of serving as the higher income earner for family and relatives both in the United States and the Philippines and having to support more dependents, may preclude them from leaving difficult work environments.

Moreover, previous research has also shown that racial ethnic minorities disproportionately experience discrimination, financial challenges related familial responsibilities and attaining advanced degrees, and lack of mentoring as barriers toward advancement in their nursing careers (Loftin et al., 2012; Schilgen et al., 2017). These current organizational work dynamics are reminiscent of historical relations between white and Filipino nurses noted earlier. Despite our findings related to the majority of these two groups securing full-time employment that allude to socioeconomic progress, our other findings also show how certain forms of labor inequities persist today, as well as potentially new forms of inequities laid bare by a global pandemic.

### 4.3 | Implications for COVID-19

From an intersectional standpoint, our study indicates some findings that infer individual and group agency and resistance related to household income, union advocacy and leadership, job satisfaction and job security for Philippines-trained RNs today. They not only are supporting family and relatives on both sides of the ocean, instead they have advocated for the betterment of the nursing profession and its work conditions for decades. However, these in-roads toward socio-economic justice appear to have come at a huge cost. Our findings and intersectional analysis also indicate that new labor inequities have also since emerged. Given the multiple news articles have recently reported the growing number of deaths amongst Filipino healthcare workers after contracting COVID-19 (Martin & Yeung, 2020; McFarling, 2020; McLaughlin, 2020), our findings confirm that these Philippines-trained RNs are disproportionately on the frontlines of acute and long-term inpatient care settings compared to their white counterparts, who are more likely to be working in outpatient, non-acute, ambulatory, clinic settings. Hence, Filipino nurses appear to be more frequently exposed to patients with higher acuity illnesses, including patients with comorbidities and exhibit severe symptoms related to COVID-19 (Jain & Yuan, 2020; Nguyen et al., 2020). According to True et al. (2020), the combination of the highly transmissible nature of the coronavirus, the congregate set-up of long-term care facility settings, and the close and intimate contact that many long-term care workers have with patients, puts them at elevated risk of infection. Moreover, given the higher death toll among older adults who have contracted this virus (Mueller et al., 2020), Filipino RNs have to also consider potentially exposing their loved ones since they are more likely to live in multigenerational households and care for adult dependents.

Lastly, recent reports show that providers are deferring elective and preventive, non-acute outpatient visits (e.g., annual physicals) to decrease the risk of transmitting COVID-19 to healthcare workers and patients in their practice (Mehrotra et al., 2020). Also, many patients are avoiding these kind of provider visits to minimize exposure. Mehrotra et al. (2020) found that the number of visits to ambulatory care practices declined by nearly 60 percent when the pandemic began. Additionally, COVID-19 has rapidly transformed the landscape of ambulatory in-person care with telehealth visits (J.-H. Kim et al., 2020). Building on our comparison and relational analysis, not only was the exposure risk possibly already lower for whites, but the shift to telemedicine for outpatient visits potentially limits contact even more so, which further increases the differential in exposure to patients between these two groups.

Even though Philippines-trained RNs may no longer be dominantly viewed as a cheaper labor force, our study shows that certain oppressive structures remain given that foreign trained Filipino nurses are now an immigrant labor force disproportionately supplying the demand for medical personnel in acute and long-term inpatient care settings that have become an even more stressful and hazardous work environment due to COVID-19. From an intersectionality lens, their current work setting characterizations potentially brings to light even more pressing

structural and organizational inequities that these foreign-trained nurses face today, thus underscoring certain unequal power relations and potential labor vulnerabilities and exploitations that continue to persist between Filipino and white RNs.

#### 4.4 | Filipino American health paradox

Altogether, these findings ought to be considered as part of an emerging Filipino American health paradox. As cited earlier, Filipinos make up a large cohort of healthcare workers in the United States. A recent study conducted by some of the authors on this paper, uncovered that Filipinos had the most health disparities compared to other Asian American subgroups and Filipinos had a higher prevalence of fair or poor health compared to non-Hispanic whites (Adia, Nazareno, Operario, & Ponce, 2020). Rather than viewing these findings as distinct, we assert that these issues are intersectionally and fundamentally linked and have led to an alarming contradiction. On one hand, Filipinos are major providers of healthcare services to the U.S. populace—including (as our findings allude to) some of the most vulnerable populations in public safety net settings; yet they are burdened by significant chronic health inequities themselves. In relation to the pandemic, Filipino RNs appear to be risking their lives by working on the frontlines to care for really sick and contagious patients. However, they too are suffering from unaddressed comorbidities (e.g., hypertension, diabetes, heart disease, asthma, excess weight) (Adia et al., 2020) associated with COVID-19 severity that can help explain the disproportionate number of Filipino nurses' COVID-19 related vulnerability and deaths in the workplace—all while facing enduring labor inequities and legacies of gendered and racialized tensions.

## 5 | CONCLUSION

The lack of change in the current infrastructure of the U.S. healthcare delivery that speaks to the enduring legacy of imperialism. As women continue to make up the majority of this workforce, our findings also underscore how these systems structure inequality hierarchically in the context of nursing care and the displacement of undesirable labor conditions to immigrant women. Instead of structurally addressing insufficient staffing, unacceptable nurse-patient ratios, and untenable workloads that have in part led to exodus of U.S. trained RNs from their job or even from the profession in general as mentioned earlier, administrators have hired foreign-trained nurse recruits to fill these positions.

In a time of a global pandemic, Philippine trained RNs appear to now bear even more severe working conditions. However, less attention is focused on the impacts of the intersecting social structures and historical precedents and its compounding impacts (Brush, 2010). While white RNs are finding these positions less appealing and opting for outpatient work settings, Filipino RNs may be less inclined to leave these stressful work environments despite suffering burnout because of the confluence of transnational pressures, unequal power relations, and socioeconomic factors influenced by a colonial past that have entrapped them into staying. Despite spaces of resistance and socioeconomic progress, the accumulation of these findings underscores the persistent inequitable power dynamics between these two groups and our relational analysis exposes how white RNs maintain their racial and class status while the Philippines-trained RN workforce no longer just serves as a “solution” to the ongoing national nursing shortage, but may now be disproportionately risking their lives in a time of a global pandemic.

### 5.1 | Benefits and limitations

There are important benefits to using data from the 2018 NSSRN for our analyses. Because the NSSRN is a nationally representative survey, external validity is strengthened and our findings are more generalizable to our

target populations: Philippines-trained nurses and white US-trained nurses. Additionally, the NSSRN is one of the only nationally representative surveys to track Philippines-trained nurses, which allowed for our analyses. These analyses also have several limitations. First, the NSSRN is a nationwide survey not intended to focus on Philippines-trained nurses; as a result, our analyses were fairly limited given the relatively small proportion of such nurses in the 2018 iteration, reducing our ability to detect more subtle differences between the groups in our analyses. Second, because we relied on secondary analyses of a large nationwide survey, important, relevant questions that are key to understanding the experiences of Philippines-trained nurses (e.g. regarding remittances, familial history or patterns of nursing) still exist and should be answered in further work. Another key element missing is the ability to assess the nurses included in the NSSRN's own health, which could provide insights into how these essential workers within the American healthcare system are faring with their own health. Third, the multivariable analyses describe an association and should not be interpreted as causal. Lastly, while the 2018 NSSRN represents relatively recent data, it is important to recognize that the COVID-19 crisis may have shifted responses or settings of care in ways that should be examined in future work (using this paper as a baseline).

## 5.2 | Future research

Moving forward, further quantitative and qualitative research is needed to understand the health, wellbeing, and lived experiences of Philippines-trained nurses, and more broadly Filipino nurses. Moreover, given the occupational burnout rates, this work could expand on previous critical nursing scholarship that has underscored the labor inequities found between for-profit, large corporate chains versus nonprofit and publicly owned facilities (Harrington et al., 2020) and how higher staffing levels in nursing homes have reduced rehospitalization and emergency room usage (Spector et al., 2013). Qualitative research on Filipino nurses can elaborate on the findings of our quantitative analyses, providing a more robust understanding of Filipino nurses' perspectives and lived experiences, including the "emotional labor" aspect of their work (Hochschild, 1983) and the up rise in xenophobic discrimination against Asians and those of Asian descent (Human Rights Watch, 2020).

Lastly, future scholarship should integrate an intersectionality framework that includes historical perspectives of imperialism and colonialism in situating public health realities, as provided in this analysis. The conquest of the Philippines by the U.S. and its impact on health, medicine, and labor is part of a broader history and enduring legacy of colonialism and imperialism in public health. Throughout the twentieth century and into the present, public health has been an important tool by the United States to maintain military or commercial control (e.g., Haiti during U.S. occupation from 1915 to 1934) and complete imperial projects (e.g., controlling malaria and yellow fever for construction of the Panama Canal in the early 1900s) (Reichardt, 2020; Stern, 2005). Incorporating these histories and enduring legacies of colonialism and imperialism underscore the need to critically integrate more critical analyses in public health scholarship to more fully understand and meet the needs of impacted populations, like Filipino nurses.

## DATA AVAILABILITY STATEMENT

The restricted data file from the 2018 NSSRN contains all information collected in the questionnaire. The file is available to the research community through an application process maintained by the Research Data Center at the Census Bureau. Click here to apply and access the data: (<https://www.census.gov/programs-surveys/ces/data/restricted-use-data/apply-for-access.html>). A list of Restricted-Use Demographic Microdata administered by the Census Bureau can be found at (<https://www.census.gov/programs-surveys/ces/data/restricted-use-data/-demographic-data.html>).

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## REFERENCES

- Adia, A. C., Nazareno, J., Operario, D., & Ponce, N. A. (2020). Health conditions, outcomes, and service access among Filipino, Vietnamese, Chinese, Japanese, and Korean adults in California, 2011–2017. *American Journal of Public Health, 110*(4), 520–526. <https://doi.org/10.2105/AJPH.2019.305523>
- AF3IRM Transnational Feminist Organization. "Honor, Visibility, & Recognition" Retrieved from: <https://www.kanlungan.net/>
- Ahmad, W. I. U., & Bradby, H. (2007). Locating ethnicity and health: Exploring concepts and contexts. *Sociology of Health & Illness, 29*(6), 795–810. <https://doi.org/10.1111/j.1467-9566.2007.01051.x>
- Aiken, L. H. (2007). U.S. Nurse labor market dynamics are key to global nurse sufficiency. *Health Services Research, 42*(3p2), 1299–1320. <https://doi.org/10.1111/j.1475-6773.2007.00714.x>
- Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H., Giovannetti, P., Hunt J., Rafferty A. M., Shamian J. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43–53. <https://doi.org/10.1377/hlthaff.20.3.43>
- Alinea, P. G., & Senador, G. B. (1973). Leaving for abroad? Here's a word of caution. *Philippine Journal of Nursing, 42*(1), 92–94.
- American Association of Colleges of Nursing. (2019). *Nursing fact sheet*. Retrieved from <https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet>
- American Association of Colleges of Nursing. (2019). *Fact sheet: Nursing shortage*. Retrieved from <https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Factsheet.pdf>
- Apellido, R. (2018). Night shift work and weight gain among female Filipino nurses. *Journal of Obesity and Overweight, 4*(1). <https://doi.org/10.15744/2455-7633.4.106>
- Barker, L. M., & Nussbaum, M. A. (2011). Fatigue, performance and the work environment: A survey of registered nurses. *Journal of Advanced Nursing, 67*(6), 1370–1382. <https://doi.org/10.1111/j.1365-2648.2010.05597.x>
- Blakeney, B. A. (2006). *International nurse migration: Crisis or opportunity*. Retrieved from [http://www.icn.ch/triad/nna2006/Barbara\\_Blakeney.pdf](http://www.icn.ch/triad/nna2006/Barbara_Blakeney.pdf)
- Boxleg, L. (2012). The problem with the Phrase women and minorities:intersectionality-an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267–1273. <https://doi.org/10.2105/AJPH.2012.300750>
- Brush, B. L. (2010). The potent lever of toil: Nursing development and exportation in the postcolonial Philippines. *American Journal of Public Health, 100*(9), 1572–1581. <https://doi.org/10.2105/AJPH.2009.181222>
- Brush, B. L., Sochalski, J., & Berger, A. M. (2004). Imported care: Recruiting foreign nurses to U.S. Health care facilities. *Health Affairs, 23*(3), 78–87. <https://doi.org/10.1377/hlthaff.23.3.78>
- Caiola, C., Docherty, S. L., Relf, M., Barroso, J. (2014). Using an intersectional approach to study the impact of social determinants of health for African American mothers living with HIV. *Advances in Nursing Science, 37*(4), 287–298. <https://doi.org/10.1097/ANS.0000000000000046>
- Capulong, P. N. (1965). *An appraisal of the United States exchange-visitor program for Filipino nurses*. thesis. Philippine Women's University.
- Chishti, M., Hipsman, F., & Ball, I. (2015). *Fifty years on, the 1965 immigration and nationality Act continues to reshape the United States*. Retrieved from <https://www.migrationpolicy.org/article/fifty-years-1965-immigration-and-nationality-act-continues-reshape-united-states>
- Choo, H. Y. and, Ferree, M. M. (2010). *Practicing intersectionality in sociological*.
- Choy, C. C. (2003). *Empire of care: Nursing and migration in Filipino American history*: Duke University Press.
- Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the Politics of empowerment*. Unwin Hyman Press.
- Collins, P. H., Patricia H. (2002). *Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment*. (2nd ed). Routledge
- Cranford, C. J. (2020). *Home care fault lines: Understanding tensions and creating alliances*: Cornell University Press.
- Dalziel, Y. (2003). The role of nurses in public health. In A. Watterson (Ed.), *Public health in practice* (pp. 107–131). London: Palgrave Macmillan.
- Dei, G. J. S., & Asgharzadeh, A. (2002). What is to Be done? A look at some causes and consequences of the African brain drain. *African Issues, 30*(1), 31–36. <https://doi.org/10.2307/1167087>
- Elting, J. K. (2015). R02: The experiences of Filipino-American men in nursing education. *Journal of Nursing Practice Applications & Reviews of Research, 5*(1), 29. <https://doi.org/10.13178/jnparr.2015.0501.1016>
- Enano, J. O. (2020). *Dedicated US-based doctor who died of COVID-19 wanted to retire in PH*. Retrieved from <https://globalnation.inquirer.net/188790/dedicated-us-based-doctor-wanted-to-retire-in-ph>
- Espiritu, Y. L. (2003). *Home bound: Filipino American lives across cultures, communities, and countries*. University of California Press.



- Fernandez, R., Lord, H., Halcomb, E., Moxham, L., Middleton, R., Alananzeh, I., & Ellwood, L. (2020). Implications for COVID-19: A systematic review of nurses' experiences of working in acute care hospital settings during a respiratory pandemic. *International Journal of Nursing Studies*, 111, 103637. <https://doi.org/10.1016/j.ijnurstu.2020.103637>
- Flynn, L., & Aiken, L. H. (2002). Does international nurse recruitment influence practice values in U.S. Hospitals? *Journal of Nursing Scholarship*, 34(1), 67-73. <https://doi.org/10.1111/j.1547-5069.2002.00067.x>
- Francisco-Menchavez, V. (2018). *The labor of care: Filipina migrants and transnational families in the digital age*: University of Illinois Press.
- Gallardo, L. H., & Batalova, J. (2020). *Filipino immigrants in the United States*. Retrieved from <https://www.migrationpolicy.org/article/filipino-immigrants-united-states>
- Germack, H. D., McHugh, M. D., Sloane, D. M., & Aiken, L. H. (2017). U.S. Hospital employment of foreign-educated nurses and patient experience: A cross-sectional study. *Journal of Nursing Regulation*, 8(3), 26-35. [https://doi.org/10.1016/S2155-8256\(17\)30158-8](https://doi.org/10.1016/S2155-8256(17)30158-8)
- Glaessel-Brown, E. E. (1998). Use of immigration policy to manage nursing shortages. *Image - The Journal of Nursing Scholarship*, 30(4), 323-327. <https://doi.org/10.1111/j.1547-5069.1998.tb01327.x>
- Guevarra, A. R. (2009). *Marketing dreams, manufacturing heroes: The transnational labor brokering of Filipino workers*. Rutgers University Press.
- Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health*, 13(119).
- Harrington, C., Ross, L., Chapman, S., Halifax, E., Spurlock, B., Bakerjian, D. (2020). Nurse staffing and coronavirus infections in California nursing homes) *Policy, Politics, & Nursing Practice*, 21(3), 174-186. <https://doi.org/10.1177/1527154420938707>
- Hayne, A. N., Gerhardt, C., & Davis, J. (2009). Filipino nurses in the United States. *Journal of Transcultural Nursing*, 20(3), 313-322. <https://doi.org/10.1177/1043659609334927>
- Heard, E., Fitzgerald, L., Wigginton, B., & Mutch, A. (2020). Applying intersectionality theory in health promotion research and practice. *Health Promotion International*, 35(4), 866-876. <https://doi.org/10.1093/heapro/daz080>
- Hochschild, A. R. (1983). *The managed heart: Commercialization of human feeling*. University of California Press.
- Hochschild, A. R. (2000). "Global care chains and emotional surplus value". In *On the edge: Living with global capitalism*, edited by A. Giddens and W. Hutton, 130- 146. London: Jonathan Cape.
- Hohn, M. D., Witte, J. C., Lowry, J. P., & Fernández-Peña, J. R. (2016). *Immigrants in healthcare: Keeping Americans healthy through care and innovation*. Retrieved from <https://www.immigrationresearch.org/report/immigrant-learning-center-inc/immigrants-health-care-keeping-americans-healthy-through-care-a>
- Human Rights Watch. (2020). *Covid-19 fueling anti-asian racism and xenophobia*.
- Imai, H., Nakao, H., Tsuchiya, M., Kuroda, Y., & Katoh, T. (2004). Burnout and work environments of public health nurses involved in mental health care. *Occupational and Environmental Medicine*, 61(9), 764. <https://doi.org/10.1136/oem.2003.009134>
- Institute of Medicine. (2003). *The future of the public's health in the 21st century*. The National Academies Press.
- Jain, V., & Yuan, J.-M. (2020). Predictive symptoms and comorbidities for severe COVID-19 and intensive care unit admission: A systematic review and meta-analysis. *International Journal of Public Health*, 65(5), 533-546. <https://doi.org/10.1007/s00038-020-01390-7>
- Jurado, L.-F. M., & Saria, M. G. (2018). Filipino nurses in the United States. *Nursing Management*, 49(3).
- Kaestner, R., & Kaushal, N. (2012). Effect of immigrant nurses on labor market outcomes of US nurses. *Journal of Urban Economics*, 71(2), 219-229. <https://doi.org/10.1016/j.jue.2011.11.002>
- Kelly, U. A. (2009). Integrating intersectionality and biomedicine in health disparities research. *Advances in Nursing Science*, 32(2), E42-E56. <https://doi.org/10.1097/ANS.0b013e3181a3b3fc>
- Khullar, D., & Chokski, D. A. (2018). *Health, income, & poverty: Where we are & what could help*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hpb20180817.901935/full>
- Kim, J.-H., Desai, E., & Cole, M. B. (2020). *How the rapid shift to telehealth leaves many community health centers behind during the COVID-19 pandemic*. Retrieved from <https://www.healthaffairs.org/doi/10.1377/hblog20200529.449762/full/>
- Kim, J. U., Oleribe, O., Njie, R., & Taylor-Robinson, S. (2017). A time for new north-south relationships in global health. *International Journal of General Medicine*, 10, 401-408. <https://doi.org/10.2147/IJGM.S146475>
- Kovner, C. T., Brewer, C. S., Fairchild, S., Poornima, S., Kim, H., Djukic, M. (2007). Newly licensed RNs' characteristics, work attitudes, and intentions to work. *American Journal of Nursing*, 107(9), 58-70.
- López, G., Cilluffo, A., & Patten, E. (2017). *Filipinos in the U.S. Fact sheet*. Retrieved from <https://www.pewsocialtrends.org/fact-sheet/asian-americans-filipinos-in-the-u-s/>
- Lee, I., & Wang, H.-H. (2002). Perceived occupational stress and related factors in public health nurses. *Journal of Nursing Research*, 10(4), 253-260.

- Lofquist, D. A. (2012). *Multigenerational households: 2009-2011*. Retrieved from <https://www2.census.gov/library/publications/2012/acs/acsbr11-03.pdf>
- Lofstin, C., Newman, S. D., Dumas, B. P., Gilden, G., & Bond, M. L. (2012). Perceived barriers to success for minority nursing students: An integrative review. *ISRN nursing*, 2012, 806543-806543. <https://doi.org/10.5402/2012/806543>
- Lovell, V. (2006). *Solving the nursing shortage through higher wages*. Retrieved from <https://iwpr.org/publications/solving-the-nursing-shortage-through-higher-wages/>
- Lyons, S. T., Duxbury, L. E., & Higgins, C. A. (2006). A comparison of the values and commitment of private sector, public sector, and parapublic sector employees. *Public Administration Review*, 66(4), 605-618.
- Marcus, K., Quimson, G., & Short, S. D. (2014). Source country perceptions, experiences, and recommendations regarding health workforce migration: A case study from the Philippines. *Human Resources for Health*, 12(1), 62. <https://doi.org/10.1186/1478-4491-12-62>
- Martin, N., & Yeung, B. (2020). "Similar to times of war": The staggering toll of COVID-19 on Filipino healthcare workers. Retrieved from <https://www.propublica.org/article/similar-to-times-of-war-the-staggering-toll-of-covid-19-on-filipino-health-care-workers>
- McCall L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, 30(3),1771-1800. <https://doi.org/10.1086/426800>
- McFarling, U. L. (2020). *Nursing ranks are filled with Filipino Americans. The pandemic is taking an outsized toll on them*. Retrieved from <https://www.statnews.com/2020/04/28/coronavirus-taking-outsized-toll-on-filipino-american-nurses/>
- McLaughlin, T. (2020). *The fragility of the global nurse supply chain*. Retrieved from <https://www.theatlantic.com/international/archive/2020/04/immigrant-nurse-health-care-coronavirus-pandemic/610873/>
- Mehrotra, A., Chernew, M., Linetsky, D., Hatch, H., & Cutler, D. (2020). *The impact of the COVID-19 pandemic on outpatient visits: A rebound emerges*. Retrieved from <https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits>
- Mueller, A. L., McNamara, M. S., & Sinclair, D. A. (2020). Why does COVID-19 disproportionately affect older people? *Aging*, 12(10), 9959-9981. <https://doi.org/10.18632/aging.103344>
- Mullings, L. & Schulz, A. J. (2006). Intersectionality and health: An introduction. In A. J. Schulz & L. Mullings (Eds.), *Gender, race, class, & health: Intersectional approaches* (p. 3-17). Jossey-Bass/Wiley.
- National Nurses United. (2020). *Sins of omission*. Retrieved from [https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/O920\\_Covid19\\_SinsOfOmission\\_Data\\_Report.pdf](https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/O920_Covid19_SinsOfOmission_Data_Report.pdf)
- National Nurses United. (n.d.-a). About National Nurses United. Retrieved from <https://www.nationalnursesunited.org/about>
- Nazareno, J. (2018). Welfare state replacements: Deinstitutionalization, privatization and the outsourcing to immigrant women enterprise. *International Journal of Health Services*, 48(2), 247-266. <https://doi.org/10.1177/0020731418759876>
- New American Economy Research Fund. (2020). *Which countries do immigrant healthcare workers come from?* Retrieved from <https://research.newamericaneconomy.org/report/immigrant-healthcare-workers-countries-of-birth/>
- Newman, L. M. (1999). *White women's rights: The racial origins of feminism in the United States*. Oxford University Press.
- Nguyen, L. H., Drew, D. A., Graham, M. S., Joshi, A. D., Guo, C.-G., Ma, W., Zhang, F. (2020). Risk of COVID-19 among front-line health-care workers and the general community: A prospective cohort study. *The lancet public health*, [https://doi.org/10.1016/S2468-2667\(20\)30164-X](https://doi.org/10.1016/S2468-2667(20)30164-X)
- O'Neil, K. (2004). *Labor export as government policy: The case of the Philippines*. Retrieved from <https://www.migrationpolicy.org/article/labor-export-government-policy-case-philippines>
- Ortiga, Y. Y. (2018). Learning to fill the labor Niche: Filipino nursing Graduates and the risk of the migration trap. *RSF: The Russell Sage Foundation Journal of the Social Sciences*, 4(1), 172-187. <https://doi.org/10.7758/rsf.2018.4.1.10>
- Parreñas, R. (2000). Migrant Filipina domestic workers and the international division of Reproductive labor. *JSTOR*, 14(4), 560-580.
- Pasay-an, E. (2020). Exploring the vulnerability of frontline nurses to COVID-19 and its impact on perceived stress. *Journal of Taibah University Medical Sciences*, 15, 404. <https://doi.org/10.1016/j.jtumed.2020.07.003>
- Phua, D. H., Tang, H. K., Tham, K. Y. (2005). Coping responses of emergency physicians and nurses to the 2003 severe acute respiratory syndrome outbreak. *Academic Emergency Medicine*, 12(4), 322-328. <https://doi.org/10.1197/j.aem.2004.11.015>
- Piore, M. J. (1979). *Birds of passage: Migrant labor and industrial societies*. Cambridge University Press.
- Polsky, D., Ross, S. J., Brush, B. L., Sochalski, J. (2007). Trends in characteristics and country of origin among foreign-trained nurses in the United States, 1990 and 2000. *American Journal of Public Health*, 97(5), 895-899. <https://doi.org/10.2105/AJPH.2005.072330>
- Rafael, V. L. (2000). *White love and other events in Filipino history*. Duke University Press.

- Reichardt, E. M. (2020). "To Awaken the medical and hygienic conscience of the people": Cultivating enlightened citizenship through free public healthcare in Haiti from 1915–1934. *Medical History*, 64(1), 32–51. <https://doi.org/10.1017/mdh.2019.75>
- Rodriguez, R. M. (2010). *Migrants for export: How the philippine state brokers labor to the world* (NED - New edition ed.). Minneapolis: University of Minnesota Press.
- Rogers, A. E., Hwang, W.-T., Scott, L. D., Aiken, L. H., Dinges, D. F. (2004). The working hours of hospital staff nurses and patient safety. *Health Affairs*, 23(4), 202–212. <https://doi.org/10.1377/hlthaff.23.4.202>
- Sagar, P. L. (2015). Nurses leading the fight against Ebola virus disease. *Journal of Transcultural Nursing*, 26(3), 322–326. <https://doi.org/10.1177/1043659615574326>
- Schilgen, B., Nienhaus, A., Handtke, O., Schulz, H., Mösko, M. (2017). Health situation of migrant and minority nurses: A systematic review. *PLoS One*, 12(6), e0179183. <https://doi.org/10.1371/journal.pone.0179183>
- Spector, W. D., Limcangco, R., Williams, C., Rhodes, W., Hurd, D. (2013). Potentially avoidable hospitalizations for elderly long-stay residents in nursing homes. *Medical Care*, 51 (8), 673–681.
- Spetz, J., Gates, M., & Jones, C. B. (2014). Internationally educated nurses in the United States: Their origins and roles. *Nursing Outlook*, 62(1), 8–15.
- StataCorp. (2017). *Stata statistical software: Release 15*. StataCorp LLC.
- Stern, A. M. (2005). Public health chronicles. *Public Health Reports*. 120(6), 675–679. <https://doi.org/10.1177/003335490512000616>
- Tai, D., Shah, A., Doubeni, C. A., Sia, I. G., & Wieland, M. L. (2020). *The Disproportionate Impact of COVID-19 on racial and ethnic minorities in the United States*. *Clinical infectious diseases* : an official publication of the Infectious Diseases Society of America, ciaa815. Advance online publication. <https://doi.org/10.1093/cid/ciaa815>
- The Council for Community and Economic Research. (2018). 2018 Annual average cost of living index release. Retrieved from <http://coli.org/quarter-3-2018-cost-of-living-index-release-2/>
- The Staffs of KHN and The Guardian. (2020). *Lost on the frontline*. Retrieved from <https://khn.org/news/lost-on-the-frontline-health-care-worker-death-toll-covid19-coronavirus/>
- The World Bank. (2019). *Personal remittances, received (% of GDP)*. Retrieved from <https://data.worldbank.org/indicator/BX.TR.F.PWKR.DT.GD.ZS>
- Todaro, R., & Arriagada, I. (2020). Global Care Chains. In, Naples, N. A. (Ed.) *Companion to Women's and Gender Studies*.
- Tomaskovic-Devey D. 2014. The relational generation of workplace inequalities. *Social Currents*, 1, 51–73.
- Trucios-Haynes, E. (2002). Temporary workers and future immigration policy conflicts: Protecting US workers and satisfying the demand for global human capital. *Brandeis Law Journal*, 40(4), 967–1016.
- True, S., Cubanski, J., Garfield, R., Rae, M., Claxton, G., Chidambaram, P., & Orgera, K. (2020). *COVID-19 and workers at risk: Examining the long-term care workforce*. Retrieved from <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/>
- United States. (1989). Public Law No. 101-238 of 18 December 1989, immigration nursing relief Act, 1989. *Annual Review of Population Law*, 16, 173.
- U.S. Bureau of Labor Statistics. (2019). *Labor force Statistics from the current population survey*. Retrieved from <https://www.bls.gov/cps/cpsaat11.htm>
- U.S. Bureau of Labor Statistics. (2020). *Occupational employment and wages, may 2019: 29-1141 registered nurses*. Retrieved from <https://www.bls.gov/oes/current/oes291141.htm>
- U.S. Bureau of Labor Statistics. (2020). *Union Members - 2019* [Press release]. Retrieved from <https://www.bls.gov/news.release/pdf/union2.pdf>
- U.S. Census Bureau. (2019). 2013–2017 American community survey 5-year estimates. Retrieved from <https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2017/5-year.html>
- U.S. Census Bureau. (2019). 2018 American community survey 1-year estimates. Retrieved from <https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2018/1-year.html>
- U.S. Department of Health and Human Services. (2002). *Projected supply, demand, and shortages of registered nurses, 2000–2020*. Retrieved from: <https://files.eric.ed.gov/fulltext/ED468472.pdf>
- U.S. Department of Health and Human Services. (2019). *report Technical Report for the national sample Survey of registered nurses*. Retrieved from Rockville, MD, <https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/nssrn-technical-report.pdf>
- Volcker, P. A., & National commission on the public service. (1989). *Leadership for America: Rebuilding the public service*. Washington, D.C.: National Commission on the Public Service.
- Wexler, L. (2000). *Tender violence: Domestic visions in an age of U.S. Imperialism*. Chapel Hill: University of North Carolina Press.
- Wofford, P. (2019). *Nursing shortage: Foreign nurses provide aid to U.S. Hospitals*. Retrieved from <https://nurse.org/articles/foreign-nurses-help-us-nursing-shortage/>

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