

From Despair to Hope: Rebuilding the Health Care Infrastructure of New Orleans after the Storm

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ABSTRACT

The wide-scale devastation wrought on the Gulf Coast by Hurricane Katrina exposed what may be one of our nation's least talked about and most poorly addressed shortcomings: that we are a country of "haves" and "have nots." It is no secret that even before the hurricane the health care system in Louisiana—particularly in New Orleans—struggled to meet the needs of its residents and was mired with disparities. As we rebuild the health care infrastructure of the Gulf Coast, this resounding tragedy brings with it the hope and opportunity to redesign and rebuild a health care system that eliminates disparities and creates equality.

INTRODUCTION

On 29 August 2005, Hurricane Katrina slammed into the Gulf Coast leaving in its wake massive destruction. The worst natural disaster in the history of the United States laid bare the social and economic inequities that percolated beneath the surface of our great nation, exposing an underclass of Americans who were abandoned

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by society long before the storm hit and the levees broke. The three states that sustained the brunt of the storm's fury were Louisiana, Mississippi, and Alabama, which are also the poorest in the United States-Louisiana, with a poverty rate of 22 percent; Mississippi, with a poverty rate of 23 percent; and Alabama, with a poverty rate of 20 percent (Schneider and Rousseau 2005). In the days following the hurricane, the images of Americans standing on rooftops, pleading for rescue, and dying among the chaos were burned into our collective consciousness. Many of those-predominately people of color-were unable to evacuate because they were the poor, including the elderly, the young, and the sick.

In addition to destroying the levees, the hurricane further decimated a fragile health care infrastructure that was the lifeline to many of the medically needy and under served. In New Orleans specifically, many of the hospitals, clinics, nursing homes, community health centers, and other health care facilities were either severely damaged or completely destroyed. Many of those impacted health care facilities and providers delivered essential health care services to the poorest and most underserved communities.

The looming challenges in redesigning and rebuilding the health care infrastructure of New Orleans are great, including rebuilding physician practices and hospital systems; providing health care services to the remaining residents of New Orleans, as well as those who will eventually return; and rebuilding the educational pipeline that trained many of the physicians and health care professionals who served the poor and uninsured in the community. As overwhelming as this task may seem, however, we must not shrink from this challenge, because the tragedy of Hurricane Katrina also brings with it the hope and opportunity to redesign and rebuild a health care system that eliminates health disparities and creates health equity.

DISPARITIES IN LOUISIANA

Prior to Hurricane Katrina, Louisiana was the home to at least 4.5 million people (Louisiana Department of Health and Hospitals 2005). According to the U.S. Census Bureau's 2004 American Community Survey, nearly five in ten (45 percent) residents had family incomes below 20 percent of the federal poverty level, and the state was second only to Mississippi, which ranked number one with the highest poverty rate in the country (21.6 percent) (U.S. Census Bureau 2004). In New Orleans alone, nearly one in four (23 percent) residents lived in poverty, earning only \$16,090 for a family of three (Kaiser Family Foundation 2006).

Before the hurricane hit, the high poverty rates throughout the state correlated with the high uninsured rates. From 2003 to 2004, Louisiana had the fourth-highest uninsured rate in the nation, with about one in every five people living without any health insurance (Louisiana Department of Health and Hospitals 2005). Of those with coverage, nearly half (48 percent) were covered by private health insurance, and over one-quarter were covered by public health insurance programs: Medicaid covered 15 percent, and Medicare covered 13 percent of insured residents (Louisiana Department of Health and Hospitals 2005).

Not only was Louisiana one of the poorest states, with a significant uninsured problem, but also its health statistics were among the worst in the United States.

Moreover, there were exorbitantly high racial and ethnic health disparities. For example:

- The infant mortality rate for African Americans was twice that of Caucasians.
- The prevalence of diabetes in African Americans, Hispanics, and Native Americans was approximately double that in Caucasians.
- Almost one-third of Louisiana adults were overweight, with African Americans more likely than Caucasians to be overweight (Macklin 2003).

Prior to Hurricane Katrina, nearly one-fourth of Louisiana's population resided in the New Orleans area, and it is anticipated that more than half of all hurricane survivors will eventually return home. With the devastation of its health care service and delivery, and public health systems, Louisiana-and particularly the city of New Orleans-will not be able to meet the health care needs of its returning residents and the uninsured workers who have moved to the area to help rebuild the city. The city's health disparity challenges will persist unless the health care infrastructure is restored and rebuilt.

DAMAGE TO HEALTH CARE FACILITIES

Prior to Hurricane Katrina, Louisiana State University (LSU) operated ten state-funded inpatient hospitals and over 350 clinics, including the Medical Center of Louisiana at New Orleans (MCLNO), that primarily served the underinsured and uninsured (Kaiser Family Foundation 2006). Additionally, LSU operated nineteen other acute care hospitals and community health centers in the region (Louisiana Department of Health and Hospitals 2005).

Even though there were other hospitals in New Orleans, MCLNO, which was the *only* Level 1 Trauma Center and included Charity and University Hospitals, was a fundamental component in the backbone of the LSU health care system. The hospital provided care to the indigent, uninsured, and predominately African American and other ethnic minority population in New Orleans. In fact, more than 50 percent of inpatient care provided by MCLNO was to uninsured patients, nearly three in four of MCLNO patients were African American, and more than eight in ten (85 percent) had annual incomes that were \$20,000 or less. Among all of the hospitals in New Orleans, MCLNO accounted for nearly one in four (23 percent) emergency room visits, 14 percent of all hospital admissions, and nearly one in five (19 percent) total births in the New Orleans area (Kaiser Family Foundation 2006). Furthermore, it provided more than “25,000 discharges and more than 407,000 outpatient visits per year (including 144,000 emergency department visits) both at the hospital campus and through a network of satellite clinics. An astonishing 51 percent of its patients were uninsured and another 32 percent were covered by Medicaid” (Schneider and Rousseau 2005, 3).

After Hurricane Katrina, most of the health care service and delivery facilities in New Orleans were either severely damaged or destroyed. MCLNO was closed, and only seven of the acute care hospitals remain in operation (Louisiana Department of Health and Hospitals 2005).

According to the National Association of Community Health Centers, Katrina cost the health centers in New Orleans more than \$43 million in damage (Simmons 2005). Moreover, 15 percent of all health centers that were permanently destroyed were located in New Orleans (Duke 2005).

For those residents who remained and those who are assisting in the rebuilding efforts, health services are very limited, and health care resources are extremely scarce. In order to receive medical care, many depend upon tent cities and temporary trauma centers staffed by displaced physicians and other health care professionals. Furthermore, patients often wait days before being seen by a health care provider and getting prescriptions filled.

DISPLACED HEALTH CARE PROVIDERS

Prior to Hurricane Katrina, approximately 4,300 medical doctors and 13,000 registered nurses worked in the New Orleans region. Despite these pre-hurricane numbers, a shortage of health care professionals persisted, with a shortfall of approximately 830 health care personnel (Louisiana Department of Health and Hospitals 2005). After the storm that shortage worsened. In fact, it is estimated that over 6,000 physicians alone had been displaced in the Gulf Coast region. Of the physicians in the flood-affected areas, which included six Louisiana and four Mississippi counties or parishes, many were specialists (2,952), primary care physicians (1,292), and obstetricians/gynecologists (272) (Ricketts 2005). Many of them have been displaced throughout the country.

In New Orleans, more than two in three displaced providers (4,486) were in the three central New Orleans parishes-Plaquemines, St. Bernard, and Jefferson parishes-all of which were evacuated (Ricketts 2005). It is estimated that more than one in three (35 percent) displaced physicians in these three central New Orleans parishes were primary care physicians (Ricketts 2005). The Louisiana Department of Health and Hospitals states that in order to provide adequate primary health care services to the general and low-income populations that have started to, and are expected to continue to, return to New Orleans, St. Bernard, Jefferson, and Plaquemines parishes, need approximately ninety-five restored or new primary care practices, each with at least two primary care doctors (Louisiana Department of Health and Hospitals 2005). Furthermore, if all these practices require new construction, it could cost almost \$90 million, and that does *not* include costs associated with covering medical personnel and staffing (Louisiana Department of Health and Hospitals 2005).

INSTITUTIONS OF HIGHER EDUCATION

The devastation wrought by Katrina has not only damaged the physical structures of the New Orleans health care system, but also has drastically impacted the educational pipeline of future physicians and health care providers that serve predominantly medically needy and underserved communities in the area. Universities and colleges such as LSU, Tulane University, Xavier University, and Delgado Community College provide a vital supply of health care professionals who work in the hospitals, clinics, and community health centers that provide health care

to some of the area's most vulnerable residents. Additionally, Xavier University and Delgado Community College, in particular, play an integral role in diversifying the pool of rising health care providers. When Hurricane Katrina hit, over 1,200 resident physicians were in training in New Orleans (Ricketts 2005). Of the approximately 1,300 enrolled medical students from Tulane University and LSU, most were relocated to other programs in the region, primarily to Baton Rouge and east Texas (Ricketts 2005).

LEGISLATIVE REMEDIES

As the reconstruction of New Orleans gets underway, it is imperative that the health care providers and the medical and academic institutions, which were the foundations of the New Orleans health care infrastructure, be the foundation upon which rebuilding and restoring begins. Until that begins, however, these providers and institutions need resources to cover their funding gaps, to retain their faculty, and to allow them to continue to provide the life-saving health services to the residents who remained and are returning to the area. For example, it is estimated that the LSU Health Sciences Center will need \$98.4 million in 2006 to retain its faculty and continue to offer its health profession education and training programs (Stephens 2005).

While progress has been slow, there are myriad reasons why progress must happen, and there are indicators that progress *will* happen.

CONCLUSION

As a result of Hurricane Katrina, at least 650,000 people were evacuated from the New Orleans region, with about 290,000 evacuating to other parts of Louisiana and about 360,000 leaving the state altogether (Louisiana Department of Health and Hospitals 2005). Many of the individuals impacted were from medically needy and underserved communities. Additionally, because a disproportionate number of Hurricane survivors lacked health insurance or were grossly underinsured, they had, and continue to have, serious unmet health care needs and challenges. In fact, before the storm, Louisiana's health statistics "were among the worst in this country, even though the health care expenditures were at the national average" (Stephens 2005, 1).

As we redesign and rebuild the health care infrastructure of the Gulf Coast and New Orleans, we also must build healthy communities that create positive economic, social, political, and environmental structures that ultimately affect health care. If we redesign a state-of-the-art health care system, but the patient lives in a community that does not have a grocery store that provides fresh produce or is unable to exercise because his or her community lacks safe areas in which to exercise, we have not solved the problem. If we fail to be vigilant about the possible negative environmental impacts either created or worsened by the hurricane and subsequent flooding, fail to closely monitor residents, returnees, and workers for the environmental health impacts, and fail to act to mitigate them, we will continue to perpetuate the problems. These social determinants of health—where you live, what you eat, the stress you experience, and where your children go to school—impact our health and well-being every day. Those individuals in our society who are at the low-

est socioeconomic rung suffer the most serious health complications because they lack resources to access quality health services.

Therefore, in order to provide the necessary preventive, diagnostic treatment, dental and mental health, and hospice and primary care services to those who remain in New Orleans, as well as those survivors who are returning, it is imperative to build a health care system based on a public health approach. It must be affordable, community-based, comprehensive, and culturally competent. Equally important, such a health care system should embrace evidence-based medicine, quality standards, and health information technology. Finally, we must also take this opportunity to expand health care coverage to the low-income and uninsured residents and build a foundation that invites and encourages the community to be an active participant in its health care.

Hurricane Katrina exposed the inequities in our health care system. We must let the rebuilding of the Gulf Coast and New Orleans and its health care infrastructure show our innovation, compassion, and revolutionary vision. And we must do so in a manner that champions health care equity.

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