Katrina: Health Care System Recovery, Reform, and Renaissance

By Julie C Morial, MD, MPH

Universal Coverage

Two years after Hurricane Katrina made landfall and swept through southeastern coastal Louisiana and the metropolitan New Orleans area, a disturbing portrait of health care emerges. Established during Governor Huey Long's administration in the 1930s, the Louisiana health

Hurricane Katrina.

Source: NASA August 28, 2005 Public Domain Photo. http://images.google.com/imgres?imgurl=http://earthobservatory.nasa.gov/Newsroom/NewImages/Images/katrina_goe_2005241_lrg.jpg&imgrefurl=http://earthobservatory.nasa.gov/Newsroom/NewImages/images.php3%3Fimg_id%3D17017%26topic%3Datmosphere&h=3000&w=3600&sz=2206&hl=en&start=107&tnid=6zDzexz2kkaV-M:&tnb=125&tnw=150&prev=/images%3Fq%3Dburricane%2Bkatrina%26start%3D90%26gbv%3D2%26ndsp%3D18%26snum%3D10%26hl%3Den%26sa%3DN

Man lying underneath a freeway.

Photograph by Kevin Himmelman.

care system today is considered to be expensive and inefficient.¹ High rates of poverty and lack of financial resources were cited prior to Katrina to explain the alarming statistics that show Louisiana to be a high-spending and low-performing state.

With the destruction of much of the health care system in south Louisiana, there are a myriad of uncertainties when considering how to rebuild the infrastructure, how to protect the citizens, how to reestablish and perhaps reconfigure programs and services. The region's recovery will be affected for years to come by the decisions made today.

Our political will and enthusiastic passion for the provision of universal coverage and primary, quality-driven care must supersede any

ideological or political differences that have divided us in the past. My specific health care delivery recommendations to enact this universal coverage will follow a survey of Louisiana's current demographic, health, and economic landscape.

Poverty and Health Disparity

According to the 2000 US Census, Louisiana is the poorest state in the nation with the largest percentage of residents with incomes below the Federal Poverty Level—\$16,090 for a family of three—22% of Louisiana residents and 23% of New Orleans residents. Almost 50% of Louisiana residents live at or below twice the Federal Poverty Level.^{3,4}

Health disparities in Louisiana are a significant issue, with African

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Americans and other people of color disproportionately affected by illness and disease. These include, in particular, cardiovascular disease, cancer, and diabetes, which are among the leading causes of death in Louisiana. There is a triple layer of disparity—higher risk, higher morbidity, and higher mortality rates. An African American has a 40% greater chance of cardiovascular death, and a significantly higher mortality rate for breast cancer, for example.³

Health Insurance

In face of this higher risk, some 21% of people in Louisiana are uninsured, possibly 25% (Dwayne Thomas, MD, personal communication, 2004 May)⁴—that's 900,000 residents—compared with a national average of 18% of the total population, compared with California at 15%. Another 20% of Louisiana residents have Medicaid insurance. Pre-Katrina there were 14% uninsured and 18% on Medicaid—a 9% current gap, for a total of 315,000 citizens who lack insurance.³

Some 95% of firms in Louisiana have 50 or fewer workers and as a result there are low rates of employer-sponsored coverage. These small business jobs are tied to tourism, hospitality and service sectors; for example hotel/motel workers, tour guides, musicians, and restaurant workers including cooks (Figure 1).^{5,6}

In 2004, 62% of children resided with single parents whose average total family income was \$30,112—compared with 43% of all children in the US living with single parents whose average total family income was \$51,187. This is compounded by the highest fertility rates among single women nationally—70% of births in New Orleans and 47% of births in Louisiana are to unmarried females compared with 29%

Figure 1. Percentage of uninsured by occupation.⁶

of births occurring to unmarried or single women nationally.^{7,8}

Health Status

Louisiana is ranked 49th in the United States for overall health status.

Several health indicators include: teen birth rate, 44th; infant mortality rate, 47th; and low birth weight, 49th; with infant mortality rates for African Americans at 14.1% in Loui-

siana, and for New Orleans 10.4% per 1000 live births—twice the rate for white infants.^{2,9}

Louisiana has the fourth highest cardiovascular disease rate in the United States, with cardiovascular disease the leading cause of death in Louisiana accounting for 40% of all deaths. Diabetes, an associated condition, is present in approximately 7% of adults in Louisiana. Among African Americans this rate

Santa wish list.

Photograph by Kevin Himmelman.

Photograph by Kevin Himmelman.

Levee breach in the Ninth Ward.

of diabetes is 10.9%, and among Latinos it is 7.9%. African Americans represent some 66% of those with HIV compared with a national rate of 42%.^{2,9}

These statistics are further compounded by Louisiana's lack of access to primary health care—according to *Business Week*, Louisiana is ranked 33rd in the US for access to health care.¹⁰

Health System

Prior to August 29, 2005, New Orleans had four hospital beds per 1000 population—compared with a national average 2.8 beds—with nine acute care hospitals in Orleans Parish, and seven acute care hospitals in Jefferson Parish. Acute hospitalization is largely primary care for the citizens of Louisiana.²

In this two-tiered system, health care is the responsibility of the state, not local entities, which runs the safety net system through ten state hospitals.

Medical Center of Louisiana at New Orleans (Charity and University Hospitals) comprises 50% of all ambulatory and hospital visits. Three hundred-fifty ambulatory

clinics fulfill state mandates that all residents have access to health care services. Charity, one of the busiest Emergency Departments in the US¹¹ is the hub of this system and the only Level 1 trauma center on the Gulf Coast. It is also the dominant provider in New Orleans for substance abuse, psychiatric, and HIV/AIDS care. The population dependent on this system of care was 75% African American with incomes of \$20,000 or less. In addition, 83% of inpatient care, and 88% of outpatient care, is uncompensated.⁸

Eye Of The Storm

This is the crux of the problem: historically there has been limited access to primary care and preventive services.

Two thirds of the evacuees interviewed in Houston in the aftermath of Katrina stated that they relied on a hospital or clinic as their source of care. Sixty-two percent stated they relied on the Charity system.¹²

In summary, pre-Katrina health care delivery was: high cost, uneven quality, centralized care, and uncoordinated care that was not primary care centered. A dual system of health care delivery—one system for the insured and another for the uninsured—doesn't work and has significant detrimental consequences. These adverse consequences are that this dual system: reinforces an unbalanced financial structure; encourages excess capacity in the private sector; diverts needed resources from the public sector; decreases capacity in the public sector; and reduces health care quality for all Louisiana residents.^{2,11}

Universal Coverage

The following goals should be priorities, in my opinion.

1. Build *primary care* and *preventive care* by increasing cost-effective alternatives to reduce use of emergency rooms. The “*medical-home*” concept with an expansion of community health centers and

Photograph by Kevin Himmelman.

Downtown New Orleans.

school-based health centers will promote primary and preventive care delivery. Access and quality should be a priority at these centers with the establishment of an *urgent care* system. These centers would also have a comprehensive disease management focus for chronic conditions.

2. These community health centers should also be *centers of emergency preparedness* for communities, with a specific mission to educate and inform specific geographic entities with an evacuation plan. That plan should include all citizens with a specific focus on children, the frail elderly and the developmentally disabled. Leaders would have ready access to information about each household—including the number of members, ages, and special-needs citizens. These units would serve as centers for assisting citizens in the evacuation process. These geographic units would also be coordinated with other community institutions such as schools and hospitals in the region. Implementation of a plan would be dependent on conducting training scenarios. Each of these centers would also serve as the integral hub for *mental health* and *behavioral health* services.

3. Create *public and private partnerships* to pursue opportunities to promote health information technology, to facilitate a *Web-based, electronic medical record* system and transparency in health care information to *review costs and quality*. Reimbursement systems would be established for providers and hospitals that meet key qual-

ity standards and performance measures. Centers of excellence in medical education, research and tertiary, highly specialized health care delivery should be incorporated in these partnerships. Medical education should clearly be a priority with specific programs centered on primary care and preventative health initiatives and professions. All of the medical schools in the region, the dental school, and allied health professional schools in the state should establish loan forgiveness programs that favor service pay-back in *medical homes, centers of emergency preparedness, mental health and behavioral health* centers; service at centers in Louisiana given preference.

The time is ripe for us to embrace a model of *universal coverage* for ethical, systemic, business, and social reasons. Louisiana citizens and policymakers should argue for a social agenda for insuring all citizens by working to change the

current system to make health care less expensive and more effective. There are many opportunities for us to collaborate with national policy leaders and the learnings of other states in formulating Louisiana's health insurance connector.

Our political will and enthusiastic passion for the provision of universal coverage and primary and home-based, quality-driven care has to supersede any ideological or political differences that have divided us in the past. Our future as a functional community is dependent on our cooperation. ♦

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Flood waters outside of the Superdome.

Photograph by Kevin Himmelman.

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Tomorrow

Hope is important because it can make the present moment less difficult to bear.
If we believe that tomorrow will be better, we can bear a hardship today.

— Thich Nhat Hanh, b 1926, Vietnamese monk, activist, and writer