DISPARATE LIVES

Health Outcomes Among Ethnic Minorities in New Orleans

BY CLAUDIA S. COPELAND, PhD

Good health is a goal desired by all people, and physicians, public health personnel, and other healthcare providers strive to meet this goal. Despite these efforts and intentions, however, wide disparities exist in the quality of healthcare and health outcomes for people from different ethnic groups.

THE DEMOGRAPHICS OF THE SOUTH ARE OFTEN THOUGHT OF IN TERMS OF BLACK VS. WHITE. NEW ORLEANS, HOWEVER, IS A VERY DIVERSE CITY, EVEN BEYOND THE LARGE PERCENTAGE OF MIXED-RACE RESIDENTS.

Among nonelderly adults, for example, 17 percent of Hispanic, and 16 percent of Black Americans report they are in only fair or poor health, compared with 10 percent of White Americans, according to the U.S. Department of Health & Human Services. American Indian/Alaska Native women are twice as likely as White women to lack prenatal care, and Black (13.0 percent) and Hispanic (11.6 percent) high-school graduates are more likely than Whites (8.5 percent) to report poor communication with their healthcare provider. The proportion of new AIDS cases is almost eight times as high for Blacks and more than three times as high for Hispanics as for whites, according

to the latest data from the CDC. At the same time, the Agency for Healthcare Research and Quality (AHRQ) reports that about 30 percent of Hispanic and 20 percent of Black Americans lack a source of primary care, compared with less than 16 percent of Whites, and Hispanic children are nearly three times as likely as non-Hispanic, White children to lack primary care. Furthermore, African Americans and Hispanic Americans are far more likely to rely on hospitals or clinics for their usual source of care than are White Americans (16% and 13%, respectively, vs. 8%).

Disparities in New Orleans: awareness and action

Louisiana also has its share of such disparities. For example, as of December 2012, 74% of newly diagnosed HIV cases were Black Louisianans, even though African Americans make up only about 1/3 of the state's population. Furthermore, this group suffers from higher rates of STDs in general, compared with Whites. Considering three of the most serious health conditions in the state, African American Louisianans had the highest rates of death from heart disease, cerebrovascular disease/stroke, and cancer. In New Orleans specifically, there have been large disparities between Blacks and Whites on a number of health measures, including the incidence of diabetic complications, breast cancer diagnosis and treatment delays, and breastfeeding support.

Louisiana healthcare professionals are becoming increasingly aware of these issues, and this greater awareness seems to be having an effect on disparities. Tulane and University of Louisville researchers Jan et al. looked at hepatocellular cancer outcomes in New Orleans, and found that African Americans had significantly larger tumor sizes on admission as well as other unfavorable health factors, such as a higher incidence of Hepatitis C. Citing several studies showing racial disparities in the treatment of hepatocellular carcinoma, these researchers hypothesized that Tulane, with its program of consciously uniform care, compliance with screening for conditions like Hepatitis C, and greater sensitivity to the issue of racial disparity in healthcare, might have a better record in this regard than other American institutions. The results supported this idea; the survival of African American patients treated at Tulane was, in the end, equivalent to that of White patients.

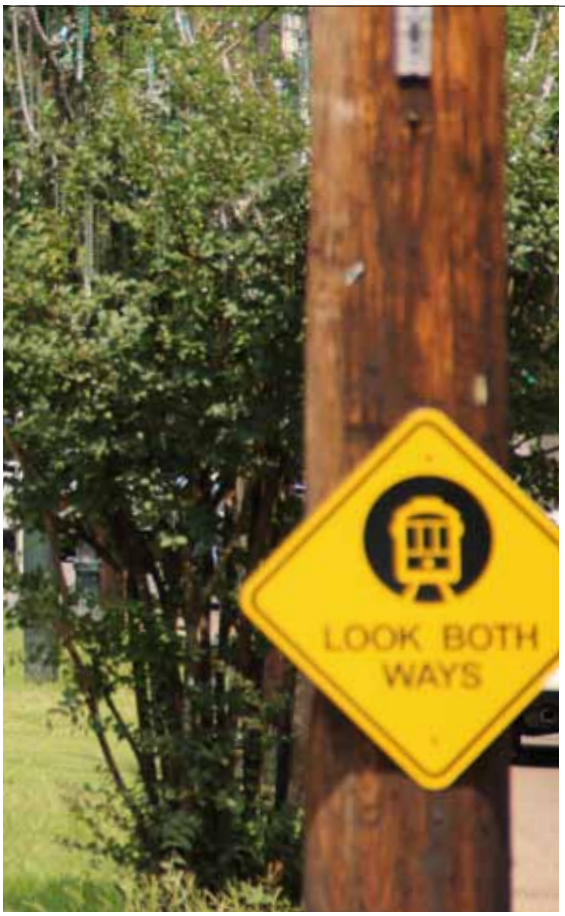
In a recent editorial, another Tulane group (Friedlander et al.) described the evolution of their efforts to engage the underserved

New Orleans African American community in cancer screening. Initially disappointed by what seemed like a lack of interest in their efforts, they engaged with community and faith-based organizations, in a genuine effort to understand why their efforts were not getting through to the population they wanted to reach. Through increased cultural understanding and a nuanced approach, they transformed their mobile cancer screening efforts from "events of fear" to "celebrations of life," with the cancer screenings coordinated with community and entertainment events. In addition to this emphasis on joyousness, they also incorporated a two-way approach to information on cancer—with an emphasis on listening as well as informing. "Our cancer awareness is a discussion in which we disseminate medical information, but also allow the community to discuss their feelings about cancer and challenges of early detection." So far, their efforts have resulted in higher participation in screening. Time will tell whether they will be successful in the long-term, but their preliminary results suggest that this approach might be a model the rest of the country could learn from.

Ethnicity in New Orleans: beyond Black and White

The demographics of the South are often thought of in terms of Black vs. White. New Orleans, however, is a very diverse city, even beyond the large percentage of mixed-race residents. Unfortunately, in spite of the efforts of organizations like the Bureau of Minority Health Access (BMHA), a division of the Louisiana DHH, to look at minority health issues with a wider lens, relatively little is known about the healthcare issues of other minorities here, which include large communities that are neither White nor Black. One such community is that of Vietnamese New Orleanians. Vietnamese-American New Orleanians are less likely to access healthcare, for several reasons. Some, such as a low rate of having health insurance, are fairly universal among minorities. Others, however, are more specific to this ethnic group, such as different cultural beliefs regarding medical treatment, especially problematic when Western models of healthcare clash with traditional Vietnamese belief systems. Language barriers may also inhibit understanding healthcare options.

Chen et al., looking at health effects following Hurricane Katrina and their implications for nurses, found that, like other New Orleanians, the health of Vietnamese-American New Orleanians after the stress of the hurricane was negatively affected by financial strain and positively affected by social support. An additional component affected this largely immigrant population,

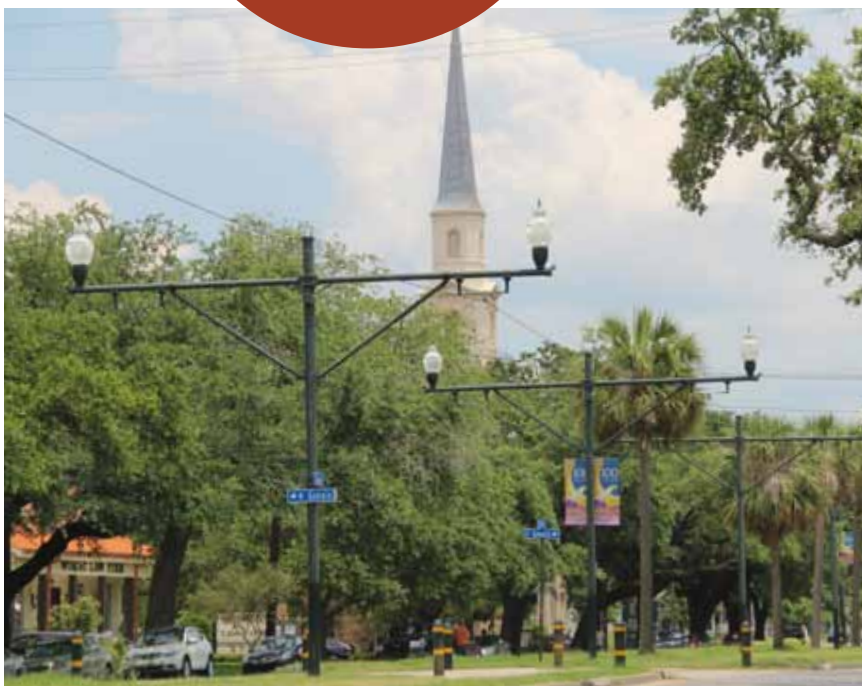


however: level of acculturation. Less acculturated Vietnamese New Orleanians had greater PTSD symptoms and poorer physical health when sociodemographic characteristics and previous traumatic experiences were controlled for. English proficiency was very important, as a lack of English proficiency severely hindered their ability to access resources and deal with complex insurance issues after the disaster. Tulane researchers Vu and Vanlandingham also reported acculturation as a unique factor affecting the health of this population, with those best described as "primarily Vietnamese" faring worse than those described as "bicultural".

Another large minority group in New Orleans, Latinos, is particularly complex due to its diversity. Comprised of immigrants and their descendents from a number of countries throughout Latin America, the Latino population in New Orleans can be further divided into two very different sociocultural groups, each with different healthcare priorities and issues. The first is comprised of long-standing Latino communities,

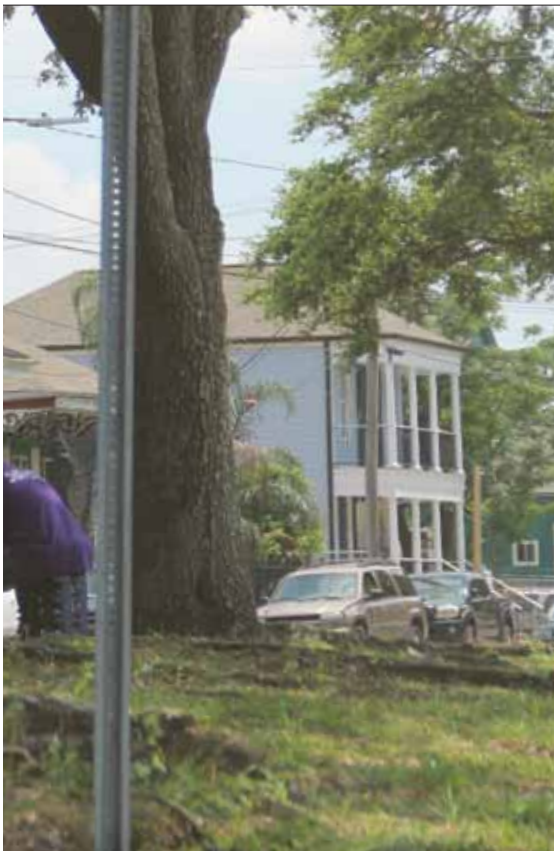
One South American construction worker, who agreed to be interviewed for this article on condition of anonymity, exemplifies the issues experienced by many newly arrived Latin American workers. He had looked into purchasing health insurance, but found it prohibitively expensive. **Overwhelmed by the complexity of the healthcare system here, he had simply given up on seeking care.**

IN A RECENT STUDY, A TEAM OF VIRGINIA COMMONWEALTH UNIVERSITY RESEARCHERS OBSERVED THAT LIFE EXPECTANCY DIFFERED BY AS MUCH AS 25 YEARS...



the largest of which is Honduran, centered in Kenner. The challenges that this group faces are similar to those of the Vietnamese and other immigrant communities, including an older generation that lacks a general awareness of issues like the need for regular diabetes screening and eye exams, and the benefits of preventative steps like flu vaccinations. Furthermore, despite having lived here for years, many of the older generation are still not comfortable enough with English to ask complicated questions about health issues.

The second Latino group is a rapidly expanding population of immigrants from Mexico and elsewhere in Central and South America (including a small but growing Brazilian population) that have recently arrived in New Orleans, largely to aid in the reconstruction of the city after Hurricane Katrina. On the one hand, these immigrants tend to be young and healthy, requiring little care for chronic health conditions. On the other hand, the overwhelming occupation of this group is construction work, a profession with numerous occupational health hazards. These include not only the potential for serious injury due to accidents, but also



heat-induced illness and other hazards more specific to New Orleans. Tulane researchers Rabito et al. tested the blood lead levels of migrant construction workers and screened them for various health symptoms. They found that respiratory, headache, and sinonasal symptoms were unusually common among the workers. Furthermore, these symptoms improved when the workers took time off work, suggesting a causal relationship with work conditions. They also found elevated blood lead levels in the workers, some severely elevated. About half of the men in the cohort had blood levels that, if persistent, have been shown to be associated with increased mortality, chronic kidney disease, and cardiovascular effects.

Besides the health risks related to working in construction in New Orleans, the migrant status of this population creates its own difficulties. For example, this group is the fastest-growing HIV-positive minority, but because of their mobility, unique healthcare outreach strategies are required. Marco Ruiz and Carlo Sebastian Briones-Chavez outlined several such strategies to address this issue, including the use of mobile clinics, social networks such as Facebook, disseminating information in Latino grocery stores, and training volunteers who teach English or provide other services to also provide healthcare information. Further complicating healthcare for this group is the undocumented status of many of these workers. Fear of deportation if the system should "get to know" them prevents many from seeking care in all but the most dire situations. The BMHA's Latino Commission is currently reviewing new immigration rulings by the courts, and how they may affect the health of this community. In addition, this commission is engaged in numerous efforts to obtain and analyze Latino health data and improve healthcare access, including to preventative care. Even workers who have legal status can feel so marginalized by the different language, culture, and system that they assume that they cannot get care for medical conditions, let alone preventative care. One South American construction worker, who agreed to be interviewed for this article on condition of anonymity, exemplifies the issues experienced by many newly arrived Latin American workers. He had looked into purchasing health insurance, but found it prohibitively expensive. Overwhelmed by the complexity of the healthcare system here, he had simply given up on seeking care. Though he suffers from severe ulcer-like symptoms, especially when under stress, he has not seen a doctor, even when the symptoms were severe enough to preclude all eating and even make drinking water difficult. He had simply concluded that it was not possible to obtain healthcare here. With limited English skills, he had no idea there were any options for people without health insurance, even in case of emergency.

Race vs. class: socioeconomic and ethnic factors in healthcare disparities

Finally, the issue of teasing out disparities based on inadequate or suboptimal treatment because of race or ethnicity from those based on lifestyle or socioeconomic factors must be addressed. Lifestyle factors certainly contribute to different health

outcomes. According to the Louisiana DHH's health disparities report, health outcomes have been shown to be influenced by social factors such as socioeconomic status (SES), behaviors, social support, stress, and environmental exposures. Also, health-seeking behavior can vary by SES, which is correlated with race; for example, low-income Louisianans are much less likely to receive cancer screening, such as mammograms, pap smears, and colonoscopies, than higher income Louisianans. However, research has also shown specific differences in health outcomes for minorities, independent of socioeconomic factors. For example, in Louisiana, infant mortality is over twice as high for infants of college-educated Black mothers as those of White mothers with the same education level. Researchers Dubay and Lebrun of The Urban Institute of Washington, DC did a meta-analysis of nationwide data to try to disentangle the effects of race/ethnicity and SES in healthcare disparities. They found that both SES alone and race alone were associated with disparities. However, while race and SES were both important factors in health outcomes, the effect of income within the same race was much higher than that of race within the same income bracket.

Further complicating matters, education is also highly correlated with health outcomes. In a recent study, a team of Virginia Commonwealth University researchers observed that life expectancy differed by as much as 25 years between a disadvantaged New Orleans zip code in which two of every five adults was a high school dropout, and a zip code where less than one of twelve residents failed to complete high school. To optimize solutions, since race and socioeconomic factors such as income and education are often correlated, it is therefore important to carefully analyze the factors underlying differences in outcomes that might otherwise be assumed to be based on either race or SES.

A number of agencies are engaged in both analysis and other efforts to address healthcare disparities. For example, the BMHA of Louisiana collaborates with Historically Black Colleges and Universities, faith-based organizations, and local governments "to identify healthcare gaps, analyze data, and consult with healthcare professionals and policy makers in order to help build community skills, capacities, and leadership." Progress is being made. According to the CDC, the infant mortality rate, previously almost double for Black Louisianans compared with White and Hispanic Louisianans, has not only declined for all groups, but has shown the greatest improvement among Black, non-Hispanic women. Efforts have also been made, at multiple levels, to comply with the "culturally and linguistically appropriate services (CLAS) standards" mandated by the U.S. DHHS in 2001. Translation services for Spanish, Vietnamese, and, more recently, Portuguese, are becoming increasingly available at health institutions in New Orleans.

Awareness is key, including both an understanding of the complex healthcare needs of the diverse and dynamic New Orleans population and a commitment to address inequities. Such awareness is the foundation for effective public health actions, conscious efforts towards evidence-based practice by physicians, and empowerment of patients to more actively pursue quality healthcare and make healthier lifestyle choices. ■

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