HISTORY OF MATERNAL AND CHILD HEALTH IN LOUISIANA

Charity Hospital in New Orleans

Our state's history is an important foundation from which to consider current racial disparities in adverse birth outcomes presented in this report.

History of Maternal and Child Health in Louisiana

A long history of racial inequality in Louisiana has impacted the health of Louisiana residents, in particular Black women and children. It is important to examine the racial disparities in adverse birth outcomes described in this report in light of the historical context of maternal and child health programming in Louisiana (Figure 2).

In 1935, Congress enacted Title V as part of the Social Security Act, seeking to protect children and mothers through an array of programs implemented by the states with the use of federal funds. In 1981, Congress consolidated these programs into the Title V Maternal and Child Health Block Grant Program, which utilizes both federal and state funds to support direct service provision to mothers and infants. Increasing Medicaid coverage of direct health services for low-income women allowed for redirection of MCH Block Grant Funds towards supportive programming. In Louisiana, these include the Women, Infants and Children program (WIC), the Nurse Family Partnership, the Pregnancy and Risk Assessment Monitoring System (PRAMS), the Maternal, Infant, Early Childhood Home Visiting Program, and others. In 1993, the Partners for Healthy Babies campaign began, which had a great impact on encouraging Louisiana women to access early and adequate prenatal care.[26]

Historically, the state-run Charity Hospital system served much of the uninsured and Medicaid population in Louisiana since the first Charity Hospital opened in New Orleans in 1736. However, Hurricane Katrina in 2005 set off a series of events that completely altered the way the Charity Hospital system functioned. The storm damaged "Big Charity" in New Orleans was forced to close and the Interim LSU Hospital took over providing similar services. These events led the way for a redesign of the entire Charity Hospital system. In 2012, the state legislature passed a plan to cut Medicaid funding by $523 million, with funding to the public health care system cut by $329 million, forcing 9 of the 10 public hospitals to enter public-private partnerships in order to stay open.

Figure 2. Timeline of Maternal and Child Health in Louisiana

1736 — L'Hospital des Pauvres de la Charite (Charity Hospital for the Poor) opened its doors at Chartres & Bienville Streets in New Orleans.

1867 — Charity moved to various locations and was run by the Daughters of Charity.

1939 — Public Works Administration built and opened a new Charity Hospital on Tulane Avenue.

1965 — Louisiana Department of Health and Hospitals (now Louisiana Department of Health) ordered the desegregation of all state hospitals.

1966 — Fewer than 10% of Louisiana's Hospitals were compliant with federal integration guidelines.

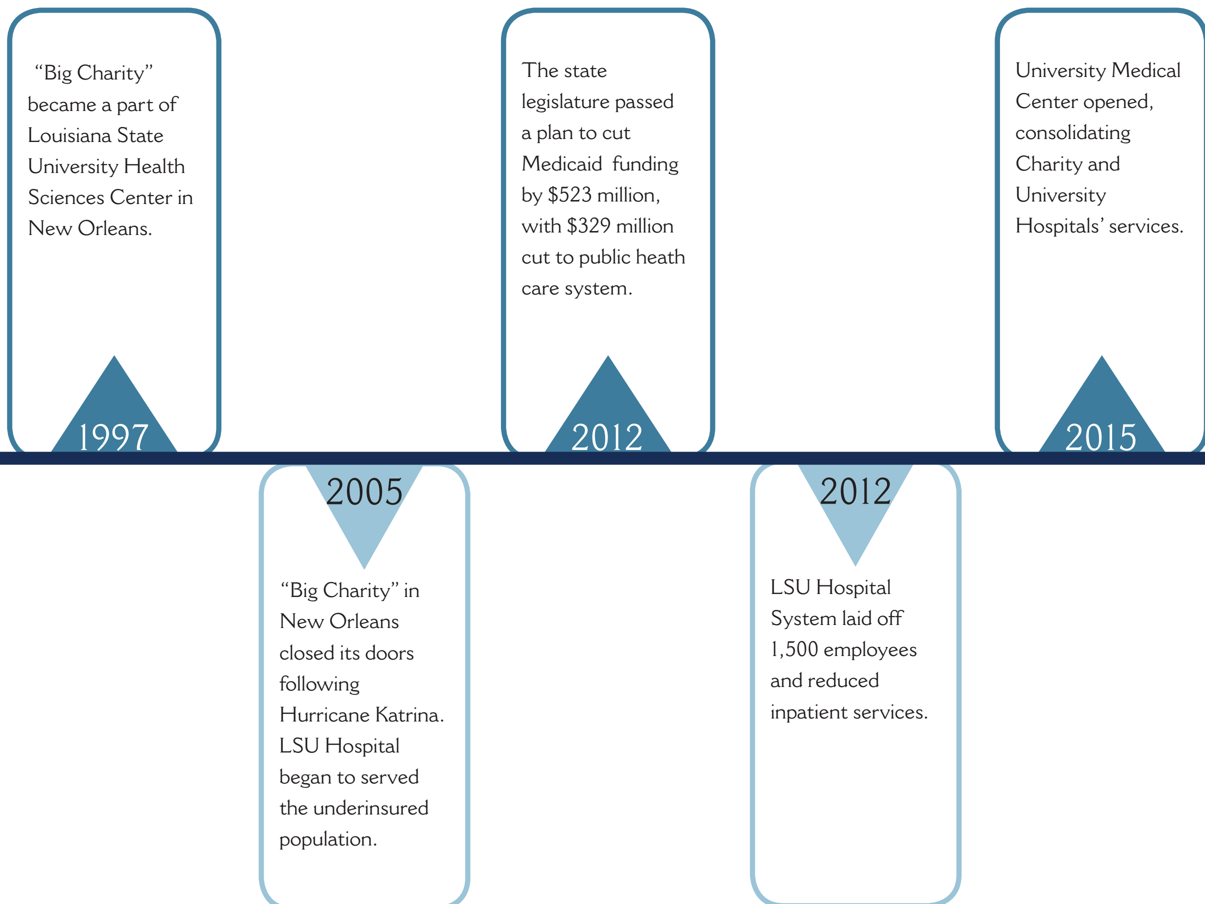
1968 — Many hospitals finally opened their doors to Black patients.

The newly constructed Medical Center of Louisiana at New Orleans consolidated the functions of the closed Charity and University Hospitals, leading to increased fragmentation of services that presents barriers for the uninsured to receive health care in Louisiana.[27]

It was not until 1965 that the Louisiana Department of Health and Human Resources (now the Department of Health and Hospitals) ordered the desegregation of all state hospitals; however, some hospitals – including Charity Hospital – took years to fully integrate.[28] Data from 1966 also shows that fewer than 10% of Louisiana's hospitals were compliant with federal integration guidelines, meaning mostly Whites received the benefits of MCH programs.[29] Many hospitals finally opened their doors to Black patients in the late 1960's and early 1970's in response to a federal requirement for hospitals to become racially integrated in order to receive Medicaid funds.

Despite these advances, racism continued to permeate local policies, institutional practices, and cultural representations. Black midwives were blamed for high infant mortality rates in the South and pushed out of practice by changing government policies.[30] As hospital births increasingly became the norm for White women, Black women continued to be the target of discrimination in Louisiana's hospitals. It was not until the late 1960's and 1970's that Black physicians were allowed to practice in Louisiana[32] and state medical colleges began to desegregate.[33]

The racial oppression and purposeful denial of equitable health and well-being outlined above has endured and adapted over time. The physical consequences of this historical trauma (the notion that a racial event – such as enslavement, war, genocide – experienced by a population in one generation can impact the health of the population many generations later) includes epigenetic alterations in gene expression, which may play a role in perpetuating disparities in adverse birth outcomes.[34,35] Today, the system of opportunities and resources in Louisiana continue to perpetuate racial inequality despite anti-discrimination legal intervention, and vast health disparities persist.



Organization of the Report

Viewed through the lens of structural racism, racial disparities in maternal and child health is an issue that requires increased collaboration between various entities within and outside the MCH world to collectively tackle root causes. This report highlights the structural, social, and cultural contexts that place some Louisiana women at greater risk for an adverse birth outcome than others. Data are presented through a series of social determinant indicators related to birth outcomes. Each indicator is presented by race/ethnicity when data are available. For some indicators, data are not presented because the number of adverse birth outcomes was too small to calculate a reliable estimate. Throughout the report, comparisons made between racial and ethnic groups use Non-Hispanic White women as the reference group because they experience the lowest rates of adverse birth outcomes.

The indicators are grouped by levels of the social-ecological model[36] (Figure 3), which allows us to highlight the range of factors operating on multiple levels that put women at risk for adverse birth outcomes. The report begins with broad, state-wide indicators that characterize the socioeconomic conditions and inequalities resulting from the society in which Louisiana women live, grow, and work (Section 1). Section 2 addresses factors at the local neighborhood and community and interpersonal levels that influence birth outcomes. Finally Section 3 describes individual-level factors (income, education, and health insurance coverage) in relation to adverse birth outcomes. The overlapping rings in the figure illustrate how factors at one level influence factors at another level. In addition, the social-ecological model suggests that in order to prevent adverse birth outcomes and reduce the disparities in rates of preterm birth and low birth weight it is necessary to act across multiple levels at the same time to ensure long-term and sustainable health equity. In the final section of the report, we provide examples of best practices and programs that have been successful in improving birth outcomes at each level, as well as recommendations to inspire action and changes to improve birth outcomes for all women in Louisiana.

Figure 3.

The social-ecological model and organization of this report