The conditions in which Louisiana women are born, grow, live, work, and age are shaped by policy choices that distribute money, power, and resources at local, national, and global levels. Health disparities arise when the distribution of resources unfairly benefits some groups more than others.
Poverty, Unemployment, Education

High levels of unemployment, poverty, and low levels of educational attainment characterize Louisiana’s population. The state ranked last for overall health in the 2015 United Health Foundation report, based on some of the lowest prevalence of high school graduation and insurance coverage and highest prevalence of children in poverty.

Within the state, some parishes fare better than others. Figure 4 shows how the percentage of babies born preterm or low birth weight is consistently higher in parishes with the highest levels of unemployment, poverty, and lowest levels of education.

Figure 4. Percentage of infants born preterm or low birth weight by parish-level socioeconomic indicators
Comparing socioeconomic indicators including poverty, education, and employment between parishes demonstrates the negative health impact of poorer conditions on all women relative to those in wealthier parishes; however, the picture is incomplete. The unequal distributions of such indicators between groups of women within each parish is one way to measure the degree of structural racism, or the systematic exclusion of people of color from access to resources and opportunities. In Louisiana, Blacks are consistently under-represented in educational attainment where across all parishes, the average proportion of Blacks with a college education is half that of Whites. While the proportion of Blacks who are employed is only 0.91 times lower on average than the proportion of Whites, the percentage who are employed in professional or managerial positions is half that of Whites and in some parishes, as much as 0.14 times lower. Voting is a measure of political participation which has been linked to better health status at the population-level (possibly because having a greater political voice influences politician’s responsiveness to citizen’s needs and concerns and constituents benefit from resources allocated in their favor). Across all parishes, Blacks were less likely to vote, on average, compared to Whites in the 2012 presidential election. Living in areas where racial inequality in these domains is large has health implications for all women in the community, regardless of race, as they experience greater rates of preterm birth and low birth weight compared to women in areas where opportunities are more racially equitable (Figure 5).

Figure 5. Excess adverse birth outcomes per 1,000 births among women in parishes with large racial inequality in structural conditions compared to women in parishes with small racial inequalities.

*P<0.05, indicating statistical significance.
Access to Prenatal Care

It has been well documented that receiving adequate prenatal care early in pregnancy lowers the risk of adverse birth outcomes. Recognizing this, the U.S. government’s Healthy People 2010 initiative has made a concentrated effort to improve prenatal care access. The goal of the initiative is that at least 90% of pregnant women will receive prenatal care within the first three months of pregnancy. Louisiana is not far off from achieving the 90% target with an estimated 87% of pregnant women receiving prenatal services in their first trimester. However, when examining the data by race, racial disparities emerge. Racial and ethnic inequality in access to healthcare in the United States have been well documented.

Research on racial and ethnic disparities in health consistently show that racial and ethnic minority populations have worse access to health services and receive worse quality of care than Whites. As previously noted, access to care and receiving quality services is an important factor for reducing adverse health outcomes, especially during pregnancy. In Louisiana, Black and Hispanic pregnant women are less likely to receive prenatal care services in their first trimester than White women. Statistics from 2010 indicate that 80% of Blacks and Hispanics receive prenatal care services in their first trimester compared to 92% of White women. Moreover, it is important to note that even after accounting for difference in socioeconomic and access-related factors, Black women tend to receive worse quality of care than Whites. Thus, when attempting to tackle racial inequities within the healthcare system the quality of services provided needs to be addressed in addition to access-related barriers.

The shortage of providers accepting Medicaid and the prohibitive costs of healthcare without insurance coverage prevent many low-income women from accessing prenatal care services. Looking at the distribution of obstetric (OB) providers across the state, there are 20 parishes that have no OB provider who accept Medicaid. The ratio of Medicaid OB providers to women in the state ranges from 1 OB doctor for every 21 women enrolled in the state Medicaid eligibility expansion program for pregnant women, Louisiana MOMs, to 1 OB for every 900 women enrolled in the program (Figure 6).

Figure 6. Ratio of Women Enrolled in LaMOMS to OB Providers who gave Birth in 2013.