

Diversity and Inclusion Committee

Tattered Tarp or New Roof: Who Gets Included in Disaster Recovery?

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In the bend of the south Texas coast, a community comes together to reflect on a year gone by since many lost everything. We danced in the streets, honored one another's hardships and congratulated each other's resilience, and I reflect on my own experience.

The last move my husband and I made before evacuating with our toddler and seven-month-old was to throw an anchor from our sailboat, sitting on its trailer, in the front yard, a hundred feet from the water's edge. "Maybe that will keep her from surfing into the neighbor's second story living room," my husband half-heartedly joked as he climbed into our small RV, wet from the first bands of the storm blowing ashore. At 5:30am, we left our home, driving in 20-minute shifts, exhausted from a day and a night of increasingly frantic preparation. Less than 12 hours later, the eye-wall of Hurricane Harvey made landfall directly on our small hometown of Rockport, Texas.

We returned to "The Charm of the Texas Coast" two days after the storm. Half of the structures were damaged beyond repair, the electrical grid was a tangle of wires and snapped poles, there was no running water, and overnight there was a new homeless population. The nearest hospital was destroyed and the majority of doctors' offices closed due to damage. Rockport (Aransas County), Texas, was already designated a Medically Underserved Area. Like so many coastal communities, it is a glaring example of wealth inequality and social stratification; vacation homes and trailer homes. The storm's destruction exacerbated an already failing safety net of health care and left our vulnerable population struggling with added mental and physical stress, financial devastation, and decreased access to primary care resources. It was obvious that the community needed a local medical response. After a short and self-guided course on legal protections for volunteer medical professionals in

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disaster zones, approval from the city Emergency Manager, and crucial support, both on the ground and remote, from a small group of graduates of the Latin American School of Medicine, I founded the Rockport Strong Mobile Medical Unit (RSMMU). For four months, RSMMU served as a pop-up urgent care clinic, staffed with volunteer physicians, nurses, and community health workers, operating out of the same RV in which my family had evacuated. Working alongside Emergency Management and FEMA, we provided free medical attention to over 400 patients.

Our team conducted a survey analysis to determine some characteristics of the population seeking our services. Some of the more important questions we asked our patients were if they had a primary care provider (61.5% reported they did not) and if they had health insurance (68% said no). And to the question, "Do you use the ED as your primary care provider?" 34% said they did. Of note, 74% of patients reported negative effects of the storm on their physical and/or mental health. The stories of

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the people represented in these figures were just as disconcerting: "I lost everything. I didn't qualify for assistance. I don't have a spare dollar to my name. My house is molding. I can't afford my prescriptions."

A year later, tattered blue tarps fail to cover the holes in roofs spaced throughout the community. Whose roof, though? Well, this is a diversity and inclusion column, so I bet you can guess. First, let's talk about disaster vulnerability and how social conditions and location lend to the potential for greater harm to some social groups during a disaster and in the immediate aftermath. Social class factors force the poor to live in substandard housing, often located in physically vulnerable areas such as flood zones and in proximity to industrial sites, and reduce the ability to undertake loss-reduction measures (boarding windows, stockpiling supplies). In the U.S., race and ethnicity are strongly correlated with social class and are also associated with increased vulnerability to disaster.¹

In the intermediate phase of disaster recovery, the same differential presents itself. Research conducted in the months following Hurricane Harvey found that the population affected differs by geography, race/ethnicity, and income, the largest impact felt by Blacks, Hispanics, and those with a self-reported income <100% FPL.² Loss of income and employment disruption had a larger effect on Hispanic, Black, and lower-income residents. Among those with home damage, low-income, Black and Hispanic residents were less likely to have had insurance. Blacks and low-income residents also reported in higher percentages that they were not getting the help they needed. Language barriers arose as a contributing factor to sluggish recovery. Three in ten individuals answering a survey in Spanish reported that it was very or somewhat difficult to find information in Spanish regarding recovery assistance. The study also

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conveyed that undocumented migrants are particularly vulnerable to the effects of natural disasters, in part out of fear of exposing themselves or family member's immigration status, and in another part due to ineligibility for benefits.

Now let's look at long-term recovery and what has recently come to light. A study published in August (2018) concludes that wealth inequality increases along the lines of race, education, and homeownership in counties badly hit by natural disasters.³ In areas with at least \$10 billion in damages, Black, Hispanic, and Asian communities saw their wealth decrease by an amount between \$10,000 and \$29,000, while white communities increased their wealth by an average of \$126,000. The study suggests that the money follows the higher levels of reinvestment via infrastructure improvements and low-interest loans after a disaster occurs, as more privileged residents gain access to new resources. Meanwhile, low-income and non-property owners are more likely to experience financial strain from losing one's job, moving, paying higher rents due to housing shortages, and depleting savings trying to compensate. Contrary to an often repeated myth, this data does not support the idea of disasters being "great equalizers." It does however bring attention to the fact that for some people the resources which flow into disaster zones can be a silver lining to a universally bad situation. I witnessed this in Rockport as it became a temporary boomtown for construction contractors, clean-up crews, and donation sites across town. The issue is that the silver doesn't seem to be making it into all folk's pockets, especially for people of color.



The rear window of the mobile medical unit.

What can we do? Disasters are great disruptors, and where there is disruption, there is room for innovation. After Hurricane Mitch slammed Honduras in 1998, Cuba responded by founding an international medical school, The Latin American School of Medicine (Escuela Latinoamericana de Medicina), designed to train doctors from lesser-developed countries, mostly people of color, who would return to their medically underserved area when they graduate so that these communities would be healthier and more prepared for disasters in the future. This plan obviously took a very long view of disaster response, as the first graduates would have returned home some seven years after Mitch made landfall. It's an example of a long-term disaster response that promotes inclusion and diversity in terms of both the medical profession and access to health care. The free mobile clinic in Rockport was a much



Mercedes Charles, MD, graduate of ELAM (Escuela Latinoamericana de Medicina) and Dr. Krause (standing) with her eight-month-old, Huck.

smaller and shorter-term response, but was still a successful innovation that brought resources to a medically underserved disaster zone. It is a model that can easily be recreated when the need presents.

The scientific community warns us that our warming planet will make high-magnitude weather events like hurricanes Katrina, Harvey, and Maria more frequent over the coming years. What does this mean for the health of communities of color exposed to these forces of destruction? Unfortunately, if disaster recovery maintains the pattern of reinforcing gaps in wealth along racial lines and the strong correlation between socio-economic status and individual health is also maintained, it's likely that the health of communities of color will disproportionately suffer. While the issues are systemic, there are roles that individual physicians can take to immediately address some of the social determinants of health at play in post-disaster communities. Here are three suggestions:

1. Set up a free clinic or volunteer to staff if one is already operating.
2. Consider in-kind donations of medical equipment.
3. Get involved with Emergency Management and advocate for the funding of programs that will improve access to health care (a community health center, for example).

Innovate. We need to change the trajectory of who gets to recovery from a disaster. The resilience and diversity of our communities depend on it. ●

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