The Health of the African Taxicab Driver in Chicago

Health Survey Report

United African Organization

February 2013

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ACKNOWLEDGMENTS

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1. EXECUTIVE SUMMARY

Chicago is home to fifth largest population of African immigrants in the United States; close to 4% of all immigrants in Chicago are African. Most African immigrants are of working age, more than half have bachelor's degrees or higher and more than 90% speak English well or very well. Despite these advantages, many African struggle to find well-paying jobs and at least 18% of the population lives in poverty. Of the 21% of all Africans who work in service occupations, taxicab drivers are estimated to make up a significant proportion. 60% of taxicab drivers in Chicago are foreign born and 6% of taxicab drivers around the country are African.

Being a taxicab driver exposes individuals to a variety of occupational hazards, including stress, long, sedentary work hours and violence, that are likely create health problems. Yet we know very little of the health related needs of taxicab drivers in general and African taxicab driver in particular. With the implementation of the Affordable Care Act (ACA), it is important to identify the needs of this population. Therefore, the United African Organization conducted a health survey among Chicago's African taxicab drivers to assess their health needs, including insurance coverage and health services use, with the hopes of working with partners to address issues that may be revealed. The African Cabdrivers Health Survey was administered to 527 African taxicab drivers between October 2012 and January 2013.

Findings from the survey indicate that African taxicab drivers have significant health related needs. Specifically, half of respondents earned at or below the federal poverty level and 66% had no health insurance. Furthermore, a third of participants had not been to a doctor in over a year, 1 in 5 respondents did not know if he had diabetes or high blood pressure, two-thirds did not know about community health centers, 71% use emergency rooms, hospitals or other safety net health providers as their usual source of care, and many live in medically underserved communities or in health professional shortage areas. Taxicab drivers also work long hours, most of which is likely spent sedentary.

In light of these findings, the following are important needs among African taxicab drivers:

- Education on the Affordable Care Act and provisions that affect them
- Linkages to programs that will enable them to make informed choices about health insurance options on the Health Insurance Marketplace
- Education and resources related to primary health care services, including community health centers
- Health education initiatives that are culturally appropriate and accessible to help them adopt preventative behaviors that can help mitigate the health hazards common in the occupation

This population also needs champions, like the United African Organization, to advocate for affordable health insurance coverage and policies that increase the availability of primary health services in the communities they live and in a format that is culturally appropriate. We hope that this report becomes the catalyst to begin making and advocating for these changes.

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2. INTRODUCTION

The immigrant population in the US and in Illinois has doubled between 1990 and 2009 (increasing by 94% and 83% respectively)[1,2] and the pace of African migration to the US has outgrown that of immigrants in general. Between 1990 and 2000, Census figures show a tripling of African immigrants in Chicago from 7,230 to 21,828; the largest numbers coming from Nigeria, Ghana and Ethiopia.[3] A decade later that number had quadrupled to more than 42,000 African immigrants in the Chicago area, now the country's fifth-largest African population in the country.[4]

Of the 1.5 million African immigrants in the United States, almost half (48%) arrived after 2000, and another third (29%) arrived between 1990 and 1999.[5] Most African immigrants are of working age; in 2009, only 5% of African born immigrants in the US were 65 years or older, 86% were between the ages of 16 and 64 and 54% were men.[5]

African immigrants are among the most educated in the United States.[6] Compared to 28% of US-born adults and 27% of all foreign-born adults, 42% of African-born adults in the US have a bachelor's degree or higher; 17% of Africans reported having a degree higher than a bachelor's, compared to 10% of US born and 11% of other immigrants.[5] In Chicago this proportion is even higher, with 57% of African immigrants have earned a bachelor's degree or higher.[1] Education levels and English proficiency among Chicago-based African immigrants is also high. More than 95% of African immigrants in the Chicago area have at least a high school education, and 93% speak English "well" or "very well".[3]

Furthermore, African-born men and women are more likely to be working or seeking employment than other foreign-born men or women.[5] About 21% of African immigrants work in service occupations, 45% work in management or professional occupations and 20% work in sales and office occupations.[1] Despite being a highly educated group, African immigrants encounter difficulties in acquiring well-paying jobs. Consequently, more African immigrants live in poverty than their US born counterparts and immigrants in general. In 2009, 18% of African immigrants lived in households with an annual income below the federal poverty level compared to 14% of the native born and 17% of immigrants in general.[5] The median household income of African immigrants was 36% below the median household income of white Americans. These income statistics may reflect a continuing degree of employment discrimination against people with a black skin.[6] These circumstances undoubtedly pose challenges to health and wellness as unemployment and underemployment often restrict access to health insurance and health care.

3. STATEMENT OF THE PROBLEM (The Health Needs of Taxicab Drivers)

Among the 21% of African immigrants in service occupations, taxicab drivers make up a significant proportion. In fact, even though there is no publicly available information on the ethnic demographics of taxicab drivers in Chicago, it is our assertion that a significant percentage of taxicab drivers in Chicago are Africa-born.

The taxicab driver profession in the US has been growing steadily over the past few decades; from 194,000 in 1990 to 230,000 in 2000 to 373,000 in 2010; a growth of 62% in the last 10 years.[8,9] The number of taxicab drivers is expected to grow by another 47,000 between 2010 and 2020 – 20% faster than the average of all other occupations.[10] Between 2010 and 2013, the number of active public chauffeur licenses in Chicago has remained around 11,800.[7,11]

Similarly, the proportion of taxicab (and limousine) drivers that are immigrants has also increased over the last few decades, from 8% in 1970 to 27% in 1990 and 28% (out of an estimated 230,000) in 2000 and about 6% of taxicab drivers in the US are from Africa.[8] This proportion is even greater in metropolitan areas like Chicago, where about 60% of taxi and limousine drivers were foreign born in 2000.[8] A study by the University of Illinois at Chicago School of Labor and Employment Relations found that 33% of taxicab drivers in their study were from Africa.[16] Another study of taxicab drivers conducted by the University of Illinois at Chicago found that while 83% of the study sample were immigrants, 50% of them were also Black.[12]

Yet there is very little information on the health of taxicab drivers. Although several studies have been conducted outside the US, studies among taxicab drivers in the US are limited. A recent study in Chicago provides some insight into their health behaviors. Among other things, this study found that about 95% of taxicab drivers did not consume the recommended amount of daily fruits and vegetables and did not participate in physical activity.[12] Furthermore, only 58% knew their blood pressure and 24% of those that did reported that their pressure was high, and of those eligible for cancer screening tests (those above 50 years of age) only one-third actually had tests performed.[12]

Despite limited information on the health of taxicab drivers, the working environment of taxicab drivers is considerably high risk, which suggests the possibility of several health-related consequences. It is characterized by long work hours fraught with a variety of occupational hazards, including stress, violence, exposure to exhaust fumes and pollutants, excessive use of stimulants like coffee and tobacco, consumption of high fat, high sugar fast foods, and long hours of physical inactivity.[13,14,15] A study among New York cab drivers found that more than 20% had cardiovascular disease or cancer and many had high blood pressure.[13]

A recent study in Chicago also found violence and safety to be significant concerns among taxicab drivers, with 43% of drivers experiencing hostile racial comments from customers, and 22% reporting being physically attacked while driving.[16] Of those attacked, a little more than one-third were robbed of their money, and a weapon was involved in about 2 out of 5 attacks.[16]

Difficulties with navigating the US medical system and lack of medical literacy are also common among immigrant groups and have been identified as barrier to accessing care. Furthermore, because the African immigrant group is made up of diverse national and ethnic groups, and of subgroups that isolate or hide themselves, providing culturally appropriate information and resources related to healthcare is challenging.

Additionally, because of their unstable employment status and income, taxicab drivers are less likely to be able to afford health insurance premiums. In New York, it is estimated that about half of cab drivers do not have health insurance,[13,14,17] which affects how often and when they seek medical advice/attention. They may be more likely to wait until they are very sick to seek care and may be less likely to seek preventive care and health screenings. Because taxicab drivers are classified as independent contractors, they also do not receive employment-based health care coverage. However, with the passing of the Affordable Care Act, taxicab drivers will be required to purchase health insurance.

4. PURPOSE OF STUDY

Recognizing this gap in knowledge, the United African Organization (UAO) is actively working to identify and address the health related challenges among African immigrant families in Illinois and across the United States. Especially in the advent of the Affordable Care Act, the UAO believes that an assessment of the health care needs of African immigrants is paramount. As a first step, the UAO implemented a brief health related needs assessment among African taxicab drivers in Chicago.

The purpose of this study is to identify the health related characteristics of African taxicab drivers in Chicago, including their health care seeking behaviors, knowledge about health care coverage options, and whether they suffer from chronic health conditions. The UAO hopes to be able to use the findings of this study to advocate for the needs of this segment of its constituency.

5. STUDY METHODOLOGY

a. Research Design and Procedures

A 25-question, anonymous survey was developed for distribution among African cab drivers in Chicago. In addition to demographic questions, the survey assessed whether respondents had health and life insurance, if they were aware of potential coverage under the Affordable Care Act, when their last doctor's visit was and where, and if they had health conditions such as diabetes and hypertension. See the *Appendix A* for a sample of the survey.

The survey was also translated into French, by an experienced translator who regularly provides translation services for the United African Association (UAO), and was made available to accommodate French-speaking African immigrants.

Field workers with extensive connections with taxicab drivers were recruited and trained to solicit and collect data. Outreach efforts were focused on relevant sites, including cab association bases, airports and hotel cab stands. Additionally, the survey was made available online and online survey completion was encouraged using flyers, emails, social media tools and word of mouth.

All participants were informed that participation was voluntary and anonymous. Precautions were taken to prevent undue influence on potential study participants and participants were able to withdraw from the study at any time.

Data collection occurred between October 2012 and January 2013.

b. Analysis/Statistical Treatment

Basic descriptive analysis was conducted on the data to identify demographic and health utilization characteristics. Additionally, we conducted statistical analysis, using SPSS, to identify relationships between variables. Specifically, the analysis sought to determine if there were relationships between demographic characteristics, such as age and income, and health service utilization and health status.

6. FINDINGS

A total of 527 African Taxicab Drivers completed the survey. According to the Chicago Department of Business Affairs and Consumer Protection, which licenses public chauffeurs in the City of Chicago, there were more than 11,700 licensed taxicab drivers as of December 2012.[18] Our sample then represented about 4.5% of the total population of taxicab drivers.

The majority of study participants were male (94%). This is similar to previous studies, which found that only about 1% to 4% of taxicab drivers in Chicago were female.[12,16] Nationally about 13% of taxicab drivers are female.[8]

The average age of respondents was 40 years old and respondents ranged in age from 21 to 69 years old. Most respondents were in the 25-44 age range (Figure 1). The majority of study participants (63%) were also married (Figure 2).

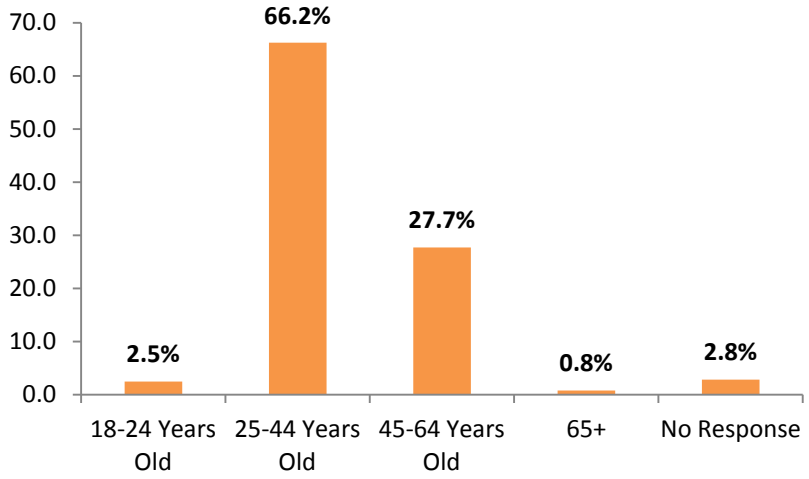

Figure 1: Age Distribution

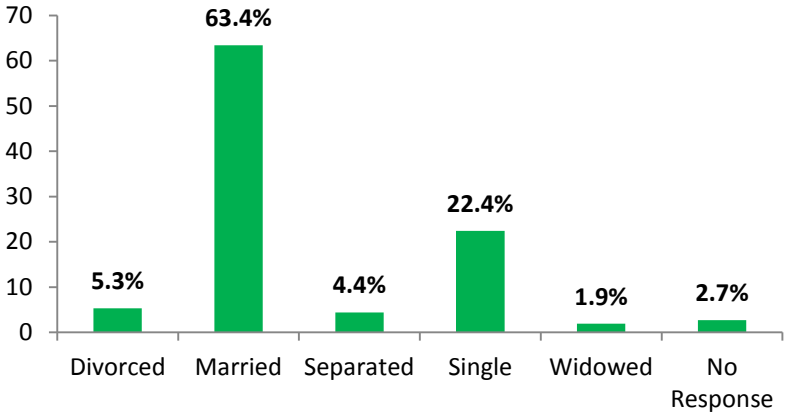

Figure 2: Marital Status

Country of Origin. Study participants represented 38 countries, with most respondents coming from Nigeria (20%), Cameroon (15%) and Ghana (13%), followed by Somalia (7%) and Benin (5%).

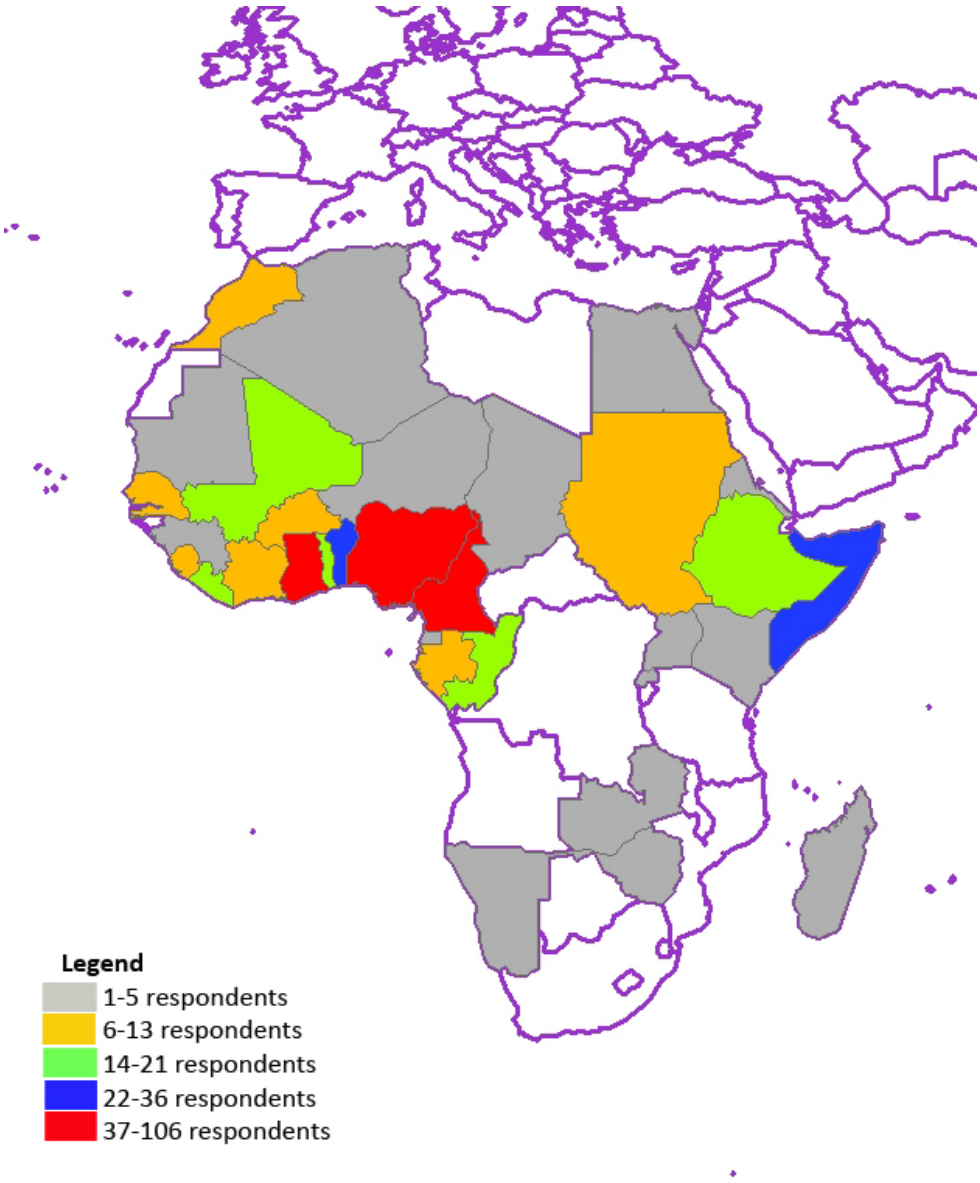

Figure 3: Country of Origin

Education. Respondents indicated a range of education levels. The majority (46%) reported college as their highest education level and 17% reported graduate degrees.

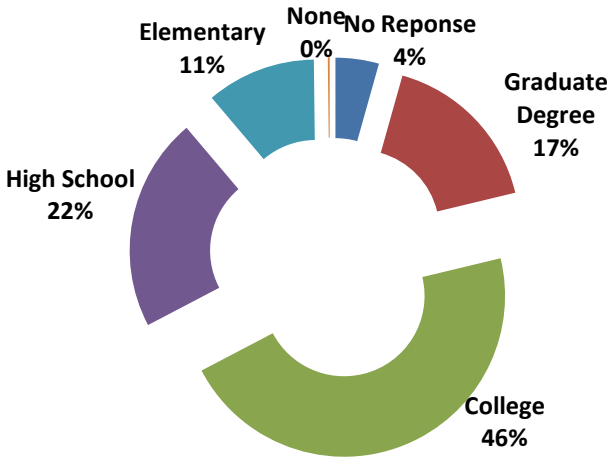

Figure 4: Education Levels

On the national level, only 14% of taxicab drivers have college degrees, and an additional 28% had attended some college. In Illinois, 22% of drivers have college degrees (2nd in the country behind Maryland) and 24% of drivers in Chicago had college degrees (2nd among metro areas behind Washington, DC).[8] Therefore, compared to national and local taxicab driver populations, African taxicab drivers are almost two times more likely to have a college degree.

English Proficiency. The **m**ajority of respondents (68%) rated their English language proficiency as 'Good' or 'Excellent' (19%). This finding is similar to the proportion of Chicago-based African immigrants who say they speak English "well" or "very well" (93%).[3]

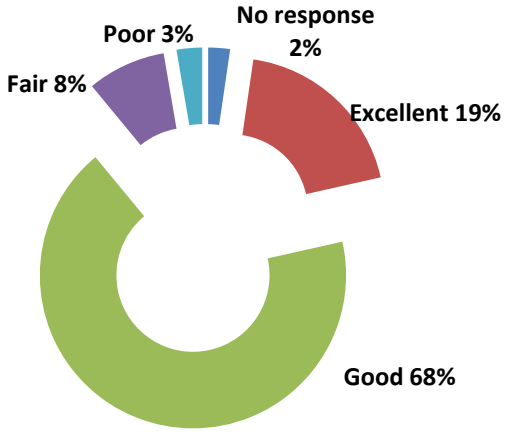

Figure 5: English Language Proficiency

Chicago Residence. The majority of respondents (47%) live on the north side of the city, while another 32% live on the south side, 7% live on the west side and 13% live in the suburbs.

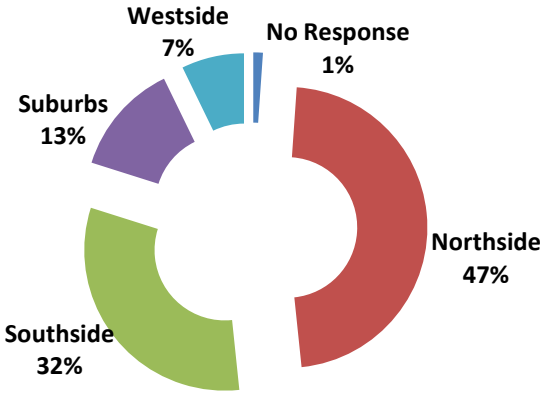

Figure 6: Chicago Residence

Zip Code Distribution. The map below (Figure 7) shows that most survey respondents are concentrated in zip codes on the north and south sides of the city. On the north side of the city, zip codes 60660, 60645 and 60640 had the highest number of respondents, corresponding to neighborhoods in the Edgewater, West Ridge and Uptown community areas respectively. On the south side of the city, neighborhoods in the Bridgeport, Near South Side, Douglas (60616), Grand Boulevard, Washington Park, Kenwood, Hyde Park (60615), South Chicago, Calumet Heights, South Deering, East Chicago (60617) and Chatham, Avalon Park, Great Grand Crossing (60619) community areas had the most respondents.

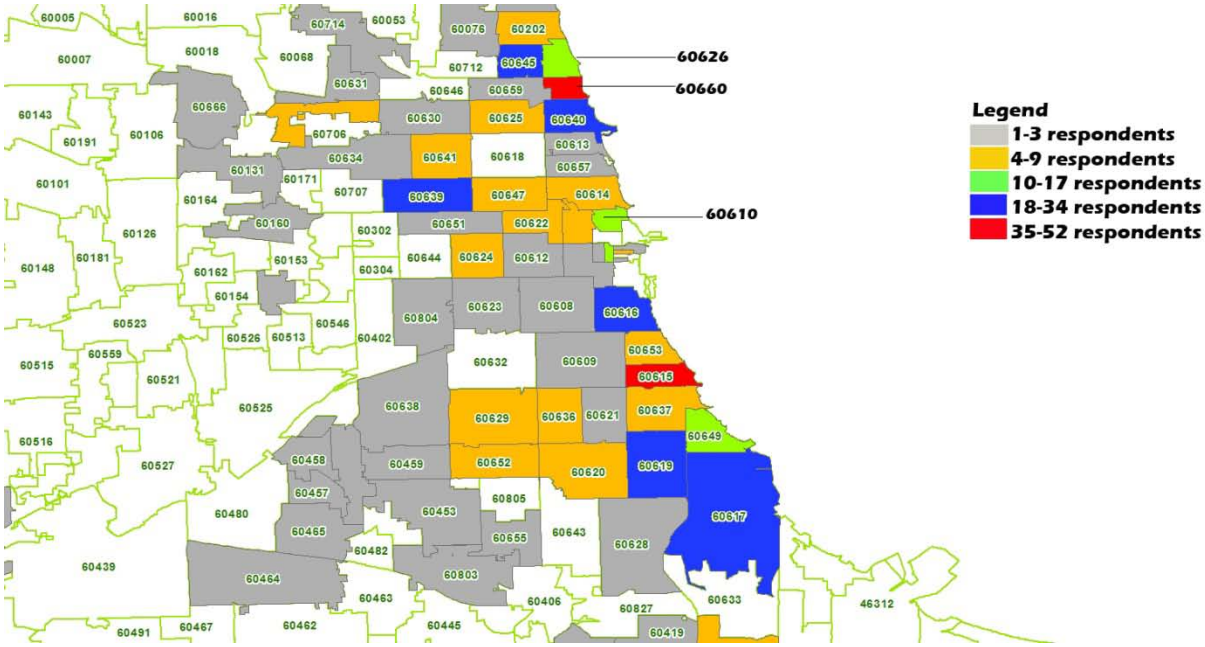

Figure 7: Map of Respondents' Residential Zip Code

While Uptown and Edgewater neighborhoods have been ports of entry for immigrants in Chicago and have large numbers of African immigrants, this data also shows us that African immigrants in the Chicago area are moving into the south and west sides of the city. However, this may have implications for the use of health and wellness services, as the south and west sides of the city are known for being medically underserved.

Income. Ninety-five percent (95%) of study participants indicated that they earn less than $50,000 a year; 50% of those reported their annual income to be less than $25,000 (Figure 8).

The US Department of Labor Statistics reports the median pay of taxicab drivers and chauffeurs at $22,440 annually and $10.79 per hour.[10] In metropolitan Chicago, the 2008 annual average income of taxicab drivers was slightly higher at $26,050.[11] A study by the University of Illinois at Chicago School of Labor and Employment Relations also found that taxicab drivers had average annual gross incomes of about $54,000 and annual expenses of about $42,000.[16] An increasing number of chauffeurs and a dwindling number of riders, as a result of the recession and a reduction in number of conventions in the Chicago area, has greatly affected the level of income among this group.[11]

In our sample, we found that income was related to age. Older drivers reported significantly higher incomes than younger drivers. Those with higher educational levels and better English proficiency were also more likely to report higher income than those with lower educational levels and poorer English proficiency.

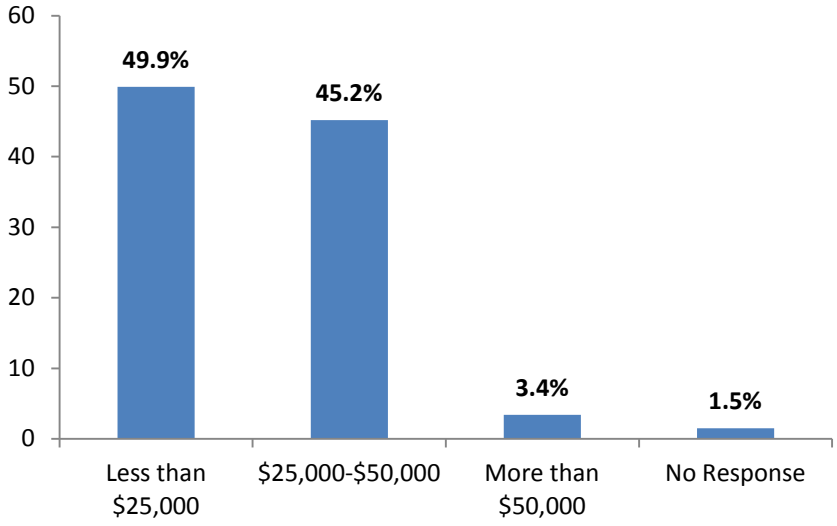

Figure 8: Annual Income

Time Spent on the Job. On average, survey participants worked 6 days a week and 12 hours a day. While the maximum reported number of days worked was 7, the maximum reported number of hours worked was 22 hours. This clearly indicates that taxicab drivers work long hours, which has the potential to contribute to health problems.

Census data also indicates that taxicab and limo drivers work long hours; 67% work 40 hours or more per week and 30% work more than 50 hours a week.[8] A study among Chicago taxicab drivers also found that they, on average, work about 13 hours a day and 24 days a month.[16]

Interestingly, those that reported working more hours per day and more days per week were more likely to report lower income than those reporting working fewer hours per day and fewer days per week.

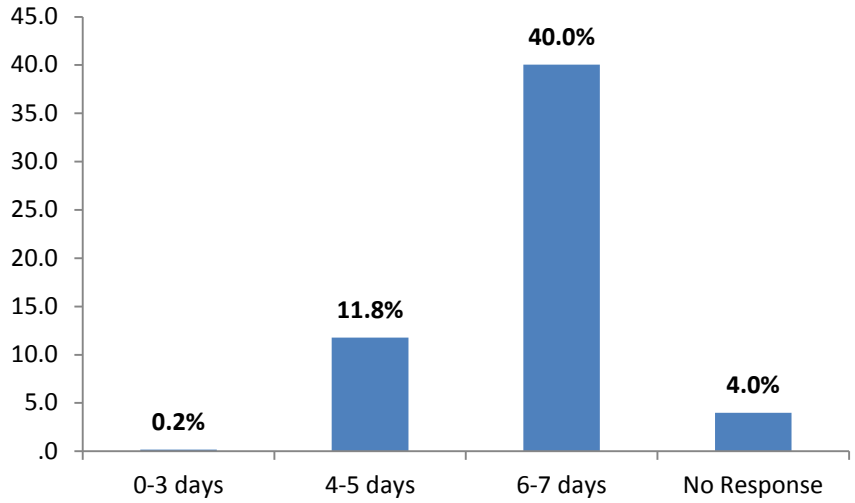

Figure 9: Average Number of Work Days per Week

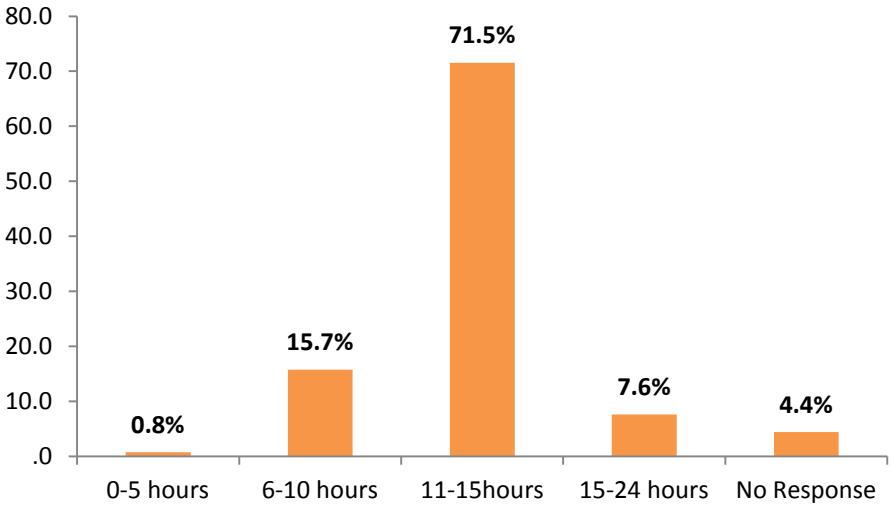

Figure 10: Average Number of Work Hours per Day

Health Status. Most participants rated their health as good (65%). Another 15% rated their health as fair and 7% rated their health as excellent. Not surprisingly, health rating was related to age – younger participants rated their health better than older participants. Participants with higher income were slightly more likely to rate their health better than those with lower income. Poorer health status was also associated with working more days per week and longer hours per day.

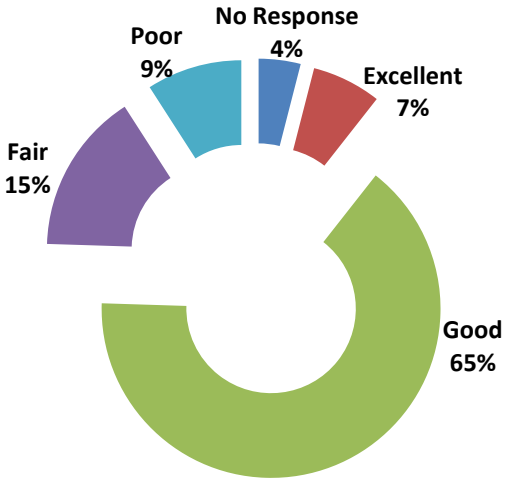

Figure 11: Health Self-Rating

Health & Life Insurance. Sixty-six percent (66%) of participants reported that they have no health insurance, which is similar to the proportion previously reported among taxicab drivers in Chicago (70%).[8] Even more respondents (83%) reported that they do not have life insurance. However, those that had life insurance were more likely to also have health insurance.

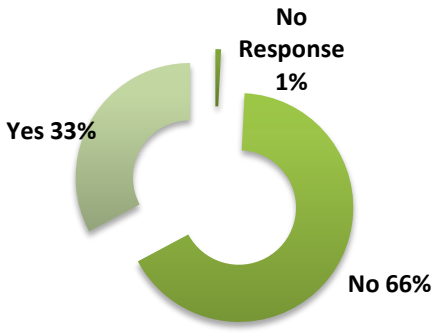

Figure 12: Health Insurance

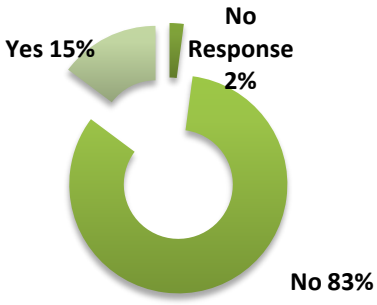

Figure 13: Life Insurance

Older participants were more likely to have life insurance than younger participants, but not health insurance. Those with higher education levels and with better English proficiency were also more likely to have life insurance than those with lower educational attainment and poorer English proficiency.

Knowledge of Health Care Coverage Options. The majority of respondents were not knowledgeable about Charity Care (73%). Charity Care refers to uncompensated (free) or discounted care provided to low income, uninsured patients by not-profit hospitals, in exchange for the hospitals having their property tax liability waived. In essence, if hospitals provide charity care comparable to their tax liability level, they can claim tax-exempt status. Patients may need to show ineligibility for other types of health insurance, including Medicaid, and provide financial information to qualify for Charity Care.[19]

However, half of respondents (50%) were aware that they may be eligible for health coverage under the Affordable Care Act (ACA).

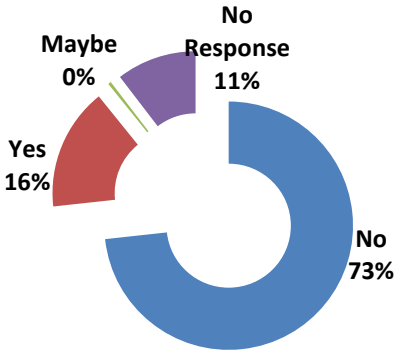

Figure 14: Knowledge about Charity Care

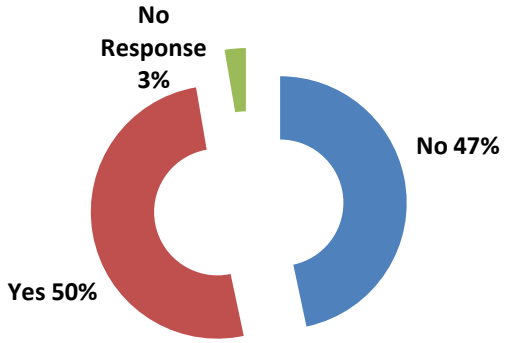

Figure 15: Knowledge of ACA Eligibility

Last Doctor's Visit. Fifty-nine percent (59%) of respondents said they had been to a doctor in the last year, while about 22% (1 in 5) of respondents reported not seeing a doctor in over a year and 13% report that they have never been to a doctor.

These findings are somewhat puzzling considering that the City of Chicago requires all public chauffeur license applicants, whether new or renewing, to submit drug testing and physical examination information, which must include tuberculosis (TB), visual and auditory screening.[7] While this may explain why a significant proportion of survey respondents reported having been to a doctor in the last year, some respondents may not consider these requirements as 'doctor visits' and subsequently reported not being to a doctor. Furthermore, we know little about what other screenings, such as blood pressure, weight/body mass index or glucose, that these 'required' doctor visits include. It is possible that the drivers are only provided screenings required for licensing with little focus on other important health issues.

Older participants were more likely to have visited a doctor more recently than respondents that were younger. Having visited a doctor recently was also related to having higher educational level, having better English proficiency, having higher income, and having health and life insurance. Those who visited a doctor recently were, however, less likely to know if they would be covered by the Affordable Care Act.

Not surprisingly, those that worked more days per week were less likely to have visited a doctor recently than those who worked fewer days per week.

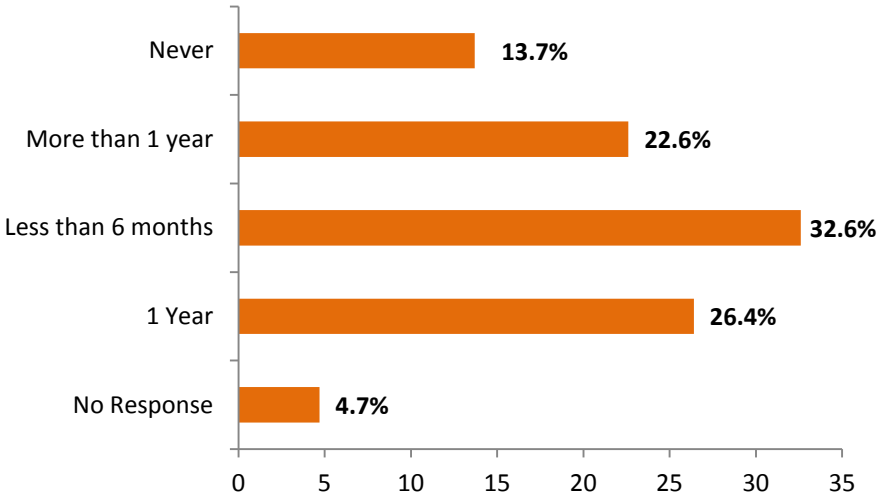

Figure 16: Last Visit to a Doctor

Normal Source of Health Care. Almost half of respondents (48%) reported that they normally go to a hospital for their health care needs. Although only 1% of respondents indicated that they used emergency rooms for their source of care, it is likely that those that indicated 'hospital' as their source of care actually use the hospital emergency room for this purpose.

An additional 17% indicated that Cook County was their normal source of health care and 5% use public health clinics such as the Chicago Board of Health Clinics. Twelve (12%) use health centers or clinics and 9% said they use 'doctors' as their usual source of care, which suggests that these respondents may have primary care providers. About 7% however indicated that they have no source of care, 1% said they use traditional healers as their usual source of care and 21% of participants did not answer this question. It is possible that those that that did not respond to this question have no normal source of health care.

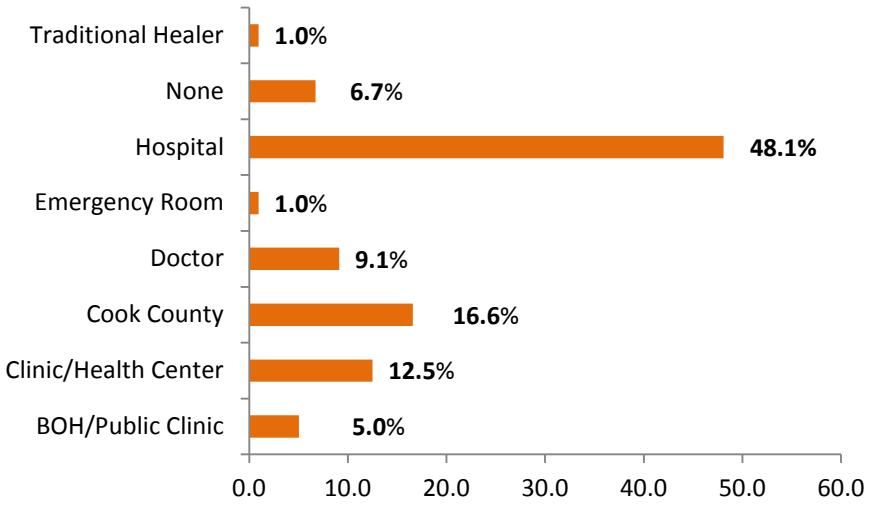

Figure 17: Normal Sources of Care

These findings indicate that a significant proportion of the study respondents, and possibly African taxicab drivers in general, do not have usual sources of care and rely on safety net medical services, such as emergency rooms and public facilities, for their care.

Knowledge and Use of Community Health Centers. The majority of respondents were not aware of community health centers; 61% indicated that they did not know what a community center is and 69% said that they have not been to a community health center. More respondents said they knew about community health centers (37%) than those that said they had been to one (27%). It is also likely that those that did not respond to the questions may also not have known what community health centers are and therefore skipped the question.

By community health centers, we meant neighborhood health centers serving the medically underserved, including the uninsured, underinsured and low-income. These health centers are federally or state funded and may be situated in areas with little access to primary health care.

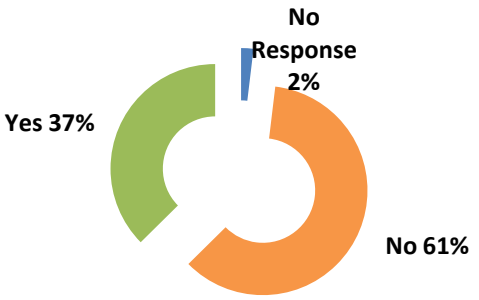

Figure 18: Knowledge about Community Health Centers

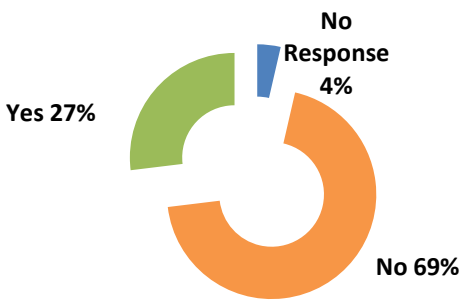

Figure 19: Use of Community Health Centers

Chronic Condition Diagnosis. While 15% of participants reported having diabetes, 21% reported having high blood pressure. The proportion of respondents who were not sure whether they had diabetes (21%) or high blood pressure (29%) was concerning. This leads us to believe that some of those that reported not having either chronic condition may actually have them and not know. Considering 13.7% of respondents reported never visiting a doctor and 22.6% reported not seeing a doctor in over a year, this is indeed a possibility, especially because these conditions often remain asymptomatic until they are in their advanced/critical stages.

Further analysis revealed that about 10% of respondents had both diabetes and high blood pressure, while 43.5% had neither health condition, and 25% were not sure if they had either condition. Fifty-five percent (55%) of respondents also reported that they know other taxicab drivers that have diabetes or high blood pressure, indicating that these health conditions are prevalent in this population.

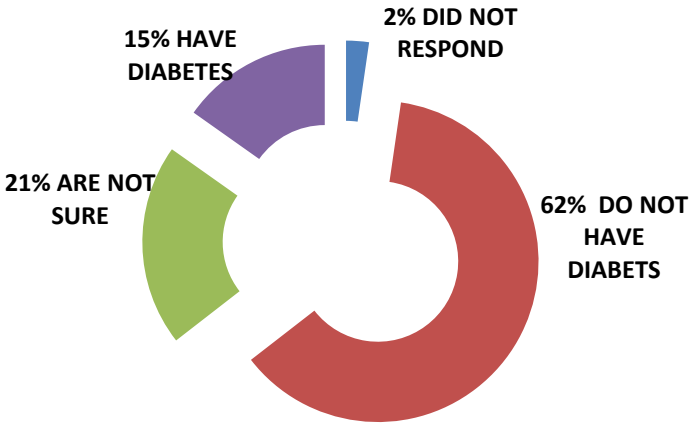

Figure 20: Diabetes Diagnosis

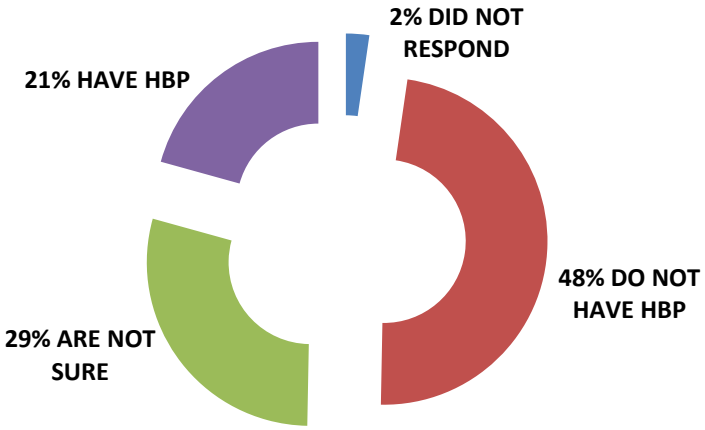

Figure 21: High Blood Pressure (HBP) Diagnosis

An evaluation of the statistical association between having high blood pressure and other relevant variables showed that high blood pressure was significantly associated with age (those with high blood pressure were more likely to be older); health rating (those with high blood pressure were more likely to rate their health poorer than those without high blood pressure); last doctor's visit (those with high blood pressure were significantly more likely to have visited a doctor sooner than those without high blood pressure); and diabetes (those with high blood pressure were more likely to also have diabetes than those without high blood pressure).

Number of days worked and number of hours worked were also significantly associated with high blood pressure – those with high blood pressure were more likely to work more days per week and more hours per day than those without high blood pressure. Conversely, those who reported working more days per week and those that reported working more hours per day were more likely to report having high blood pressure than those that worked fewer days per week and fewer hours per day. This suggests that long work days and weeks may increase the risk of high blood pressure; most likely due to increased amount of time spent sitting, increased occupational stressors and increased likelihood of consuming unhealthy foods.

Similarly, having diabetes was significantly associated with age, health rating, having high blood pressure, number of days worked per week and number of hours worked per day. Specifically, older respondents were more likely to report having diabetes; those who reported having diabetes more likely to rate their health poorer and to have high blood pressure than those with no diabetes; and those who worked more days per week and more hours per day were more likely to reported having diabetes than those who worked fewer days per week and fewer hours per day.

Cab Association Membership. The majority (89%) of respondents reported that they are currently not members of a cab association. However, 89% also indicated interest in joining an African Can Association. By association, the survey was not referring to a cab company or affiliation, of which there are 22 in the City of Chicago,[7] but rather an association that can organize and advocate on behalf of drivers regarding their health, social and financial concerns.

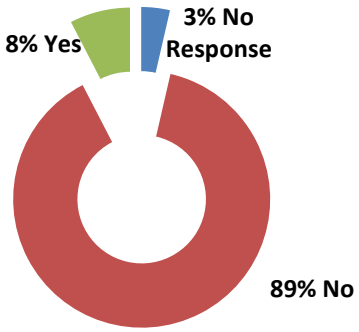

Figure 22: Current Cab Association Membership

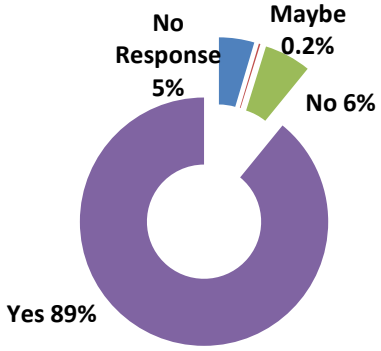

Figure 23: Interest in Membership in an African Cab Association

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7. CONCLUSION & RECOMMENDATIONS

The demographics characteristics of participants in this study have some similarities with those found in other studies of taxicab and limousine drivers around the country. The average age of taxicab drivers in our sample was slightly lower (40 years old) than the average age of taxicab and limousine drivers in general, which was 46 years.[8] Sixty-six percent (66%) of our sample was 25 to 44 years old, whereas a recent study of taxicab drivers in Chicago[8] found that only 40% of drivers in that sample were 25 to 44 years in age.

The college graduation rate among our taxicab driver sample was similar (46%) to a national sample[8] (43%), but higher than a Chicago study that reported that only 36% had college degrees. The greater education level among our sample is supported by similar findings in other studies of Africans – that they are a well educated group. In fact, our sample had higher education levels than that reported among African immigrants in general; compared to the 41.7% reported by the Migration Policy Institute[5], this study found that 63% of respondents had bachelor's degrees or higher.

Most importantly, findings from this study reveal that African taxicab drivers in Chicago have important health related needs. Two-thirds of participants in this study are of working age (25-44 years old) and two-thirds are married. Both age and marital status have implications on health insurance coverage and health service utilization. While young people are generally more likely to be healthier and considered a low risk pool by insurers, taxicab drivers are likely to have income related barriers to health insurance and health services.

About half of the taxicab drivers in this study reported earning less than $25,000 a year. We also found that another 45% of study participants reported annual incomes between $25,000 and $50,000. Other studies have also reported on the low annual income of taxicab drivers. A study by the School of Labor and Employment Relations of the University of Illinois[16] found that after accounting for costs related to being a taxicab driver, including leasing fees, fuel costs, and airport taxes, drivers in Chicago can make as little as $4.07 an hour, which is significantly below minimum wage. Such low wages can make accessing health services difficult, primarily because of the inability to afford health insurance premiums, as evidenced by the fact that two-thirds of study participants had no health insurance. Taxicab drivers are also considered self-employed and thus do not get employer-sponsored health insurance coverage.

The high proportion of married respondents are also likely to have families and because purchasing health insurance for the entire family may be costly, such families may use various alternative sources of health insurance, including federally sponsored health insurance

programs such as Medicaid and KidCare for some members of the family while others go without. Some taxicab drivers may also have health insurance coverage through their spouses' employment based coverage. Unfortunately we did not assess health insurance coverage of family members in this study.

Under the Affordable Care Act (ACA), a significant proportion of taxicab drivers would be able to get health insurance coverage, many through its Medicaid Expansion provision. For example, an individual who makes less than $14,000 a year or a family of 4 with an annual household income of less than $29,000 (this is at 133% of the federal poverty level) would meet the income eligibility for Medicaid under the ACA. Those that earn above the 133% poverty level would be required to purchase insurance through the Health Insurance Marketplace.

The uncertainty surrounding the new system and the limited knowledge regarding the provisions of and qualifications for the Affordable Care Act (ACA) among study participants indicates the need to provide information about the marketplace and assistance with selecting among health insurance options. Additionally, despite high levels of English proficiency among this group, health literacy may still be an issue and may prevent efficient navigation through the US health care system. Language proficiency and health literacy will also play significant roles in the ability of individuals to make decisions about health insurance options in the new health insurance exchange system that is a part of the Affordable Care Act. Therefore, community based agencies should target this population for outreach and education. Additionally, these services need to be culturally sensitive and take into account the varying cultural norms and beliefs about health and wellness among African immigrant groups.

Access to health services also appears to be a significant issue among this population. Although we did not assess perceptions of and satisfaction with health services in this study, cultural barriers to receiving appropriate health care services has been documented among African immigrants in general. As more Africans in the Chicago area settle outside neighborhoods that have been hubs for immigrant communities, such as Uptown, Edgewater and Rogers Park, the likelihood that they will access health care services that are culturally sensitive to their needs decreases. Additionally, many of the neighborhoods that study respondents live in, including Uptown, South Chicago, Hyde Park and Douglas, are medically underserved, which means that residents experience barriers to health services due to economic, cultural or linguistic challenges.[21] Some of these areas are also designated as primary health professional shortage areas, which means that the ratio of physician to patient is more than 1 to 3500[21] and thus residents have decreased access to physicians. Therefore, it seems appropriate for agencies that serve these populations to serve has their advocates and educate health care provides about the cultural needs of its members.

Similar to findings by Schaller Consulting[8] and Apantaku-Onayemi, et al[12], we found that taxicab drivers spend very long hours on the job. Our data also suggests that spending such long hours

on the job increases exposure to occupational hazards, including stress, which has been shown to be related to chronic diseases.[22,23] This association between chronic conditions and extended periods of time on the job is also seen among participants in this study, with those that reported longer work weeks and hours being more likely to also report poorer health status and to be diagnosed with diabetes and high blood pressure. Poor health and chronic conditions may also be prevalent among taxicab drivers because of their highly sedentary lifestyles and their consumption of low nutritional value foods, such as fast food. Apantaku-Onayemi et al.[12] report that only 5% of the taxicab drivers in their study ate the recommended levels of fruits and vegetables and participated in physical activities and 40% reported that they *never* exercised. These findings show that taxicab drivers need information, resources and skills to help them mitigate their risks associated with stress, lack of physical activity and bad dietary intake.

Furthermore, despite health screening requirement for licensing, more than a third (36.3%) of respondents have not been to the doctor in over a year. It is also possible that those that did visit a doctor recently did not receive health assessments beyond what was required for licensing. This suggests that taxicab drivers in general underutilize primary and preventive care. Despite 72% of respondents rating their health as good or excellent, it is important to note that most chronic health conditions, including diabetes and hypertension, are asymptomatic until they are well advanced. Therefore, it is important to encourage taxicab drivers to visit their doctors for preventative screenings on a regular basis.

However, working long hours was also related to not having visited a doctor recently. This suggests that taxicab drivers may be neglecting their health and not seeking routine care in exchange for remaining on the job and earning more income, especially at a time when the business is highly competitive due to higher numbers of drivers and fewer passengers. To access this population, therefore, these health education and promotion services and resources may need to be provided by mobile service providers at the locations that taxicab drivers are known to spend significant amount of time.

Additionally, it is important to increase knowledge and use of community based centers among this population. The large percentage of study participants that said they use ER, hospitals, Cook county and other safety net providers (71%) as their usual source of care, and the large number of study participants that did not know about (61%) or use (69%) community health centers is concerning. It is also likely that those that reported having no normal source of health care would end up accessing care in emergency rooms. Therefore, in addition to decreasing the use of emergency rooms and other safety net providers for routine or non-emergency health care, such knowledge will also be critical in linking taxicab drivers and their families to primary care providers and ensuring that they have medical homes where their care is coordinated and holistic.

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8. LIMITATIONS

Like all studies, this study is not without its limitations. First of all, the study relies on self reported data, which is always prone to bias, including desirable response bias where participants respond in a way they believe the researcher want them to. Therefore, we should interpret such findings with some caution. However, we attempted to minimize such bias by providing for anonymous and voluntary participation.

This study achieved outstanding participation in a short period of time - a total of 527 African taxicab drivers completed the survey. However, not all participants responded to all survey questions. Therefore, for each question, we also reported the proportion of participants that did not respond to the question. Some questions may also have been confusing or too vague for participants to answer confidently. For example, because we did not provide definition of terms, such as community health centers, it is possible that some participants may have been confused by the question and thus may not have responded accurately or may have skipped the question.

Due to the absence of a comprehensive list of African taxicab drivers in Chicago, random sampling of participants was not possible. Instead we used a convenient sample; field workers went to sites known to be frequented by taxicab drivers and approached potential participants. Therefore, it is not possible to generalize these findings to other populations of taxicab drivers; nor is this sample truly representative of African taxicab drivers in Chicago. However, it does provide valuable (and currently the best) information on the health related needs of the target population.

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APPENDIX I: SURVEY SAMPLE

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United African Organization

African Cabdrivers Health Survey

This short survey asks questions about your experiences with health care in Chicago. Please take a few minutes to answer all questions by circling or filling in the best answer. All information provided will be kept confidential. We do not collect your name and we do not ask about your immigration status or social security number. This survey is part of our African Health Education, Outreach & Advocacy Project which seeks to enhance our community access to healthcare. Your participation is greatly appreciated!

1. Gender: **Male** **Female**

2. Age: _____

3. Which country in Africa are you originally from? _____

4. What is your highest level of education? **Elementary** **High School** **College** **Graduate Degree**

5. How would you rate your English proficiency? **Excellent** **Good** **Fair** **Poor**

6. What part of Chicago do you live in?
   Northside **Southside** **Westside** **Suburbs**

7. What is your zip code? _____

8. What is your marital status? **Single** **Married** **Divorced** **Separated** **Widowed**

9. What is your yearly income?
   Less than $25,000 **$25,000 - $50,000** **More than $50,000**

10. How would you rate your overall health today? **Excellent** **Good** **Fair** **Poor**

11. Do you have health insurance? **Yes** **No**

12. Do you have life insurance? **Yes** **No**

13. When was the last time you visited a doctor?
    Less than 6 months **1 year ago** **More than 1 year ago** **Never**

14. Have you heard about community health centers? **Yes** **No**

15. Have you been to a community health center? **Yes** **No**

16. Where do you normally go to receive health care? _____

17. Do you know about Charity Care, which pays your medical bills if you don't have insurance? **Yes** **No**

18. Do you know if you are covered by the Affordable Care Act (Obama Care)?
    Yes **No** **Maybe**

19. Do you have diabetes? **Yes** **No** **Not Sure**

20. Do you have high blood pressure? **Yes** **No** **Not Sure**

21. Do you know any cabdrivers who have diabetes or high blood pressure? **Yes** **No**

22. How many days do you work per week? _____

23. How many hours do you work per day? _____

24. Are you a member of any association of cabdrivers in Chicago? **Yes** **No**

25. Are you interested in an African Cabdrivers Association in Chicago to advocate on your behalf?
    Yes **No**

Thank You!!!!!!
Merci Beaucoup!!!!!

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