

# Historical Geography and Health Equity: An Exploratory View of North Carolina Slavery and Sociohealth Factors

Nicole Dozier, William H. Munn

**Current health inequities are rooted in more than simple systems failures and inefficiencies. Historical legacy has corrupted health outcomes, and resolution requires both acknowledgment and intention.**

One might ask, “What does Rutherford B. Hayes’s decision to withdraw the remaining federal troops from the South in exchange for being declared president in the contested election of 1876 have to do with present-day health inequities in North Carolina?” More than one might think.

The Compromise of 1877 awarded Hayes the presidency and removed federal troops from the South, setting the stage for the death of Reconstruction and the birth of Jim Crow. Since then, structural racism has been baked into the foundation of Southern domestic policy, but this legacy and how it continues to perpetuate health inequities are too often overlooked. Any serious conversation about the eradication of such disparities should not be undertaken without first acknowledging the ever-present and insidious role of white supremacy: the ideology necessary to justify bondage of human beings, exploitation of their labor, implementation of Jim Crow, and the denial of the compounded impact these systems have had on every facet of present-day African American life, including health outcomes [1].

Emerging literature makes some initial connections between ideology and poor health outcomes. In their book *Deep Roots*, authors Avidit Acharya, Matthew Blackwell, and Maya Sen explore the correlation between the deeply entrenched political and racial views of Southern whites and their region’s slaveholding history [2]. They use examples of current political attitudes of whites in Greenwood, South Carolina (68% enslaved in 1860), versus those of Asheville, North Carolina (15% enslaved in 1860) [2]. In a 2014 article, they point out that after the Civil War, Southern whites living in areas traditionally reliant on slave labor embraced political and economic incentives to “reinforce racist norms and institutions to maintain power over newly freed Blacks,” power that has been used to deprive them of wealth and health through intentional policy [3]. In Jim Downs’s *Sick from Freedom*, we learn that after the Civil War, health care

leaders vacillated with whether to treat the newly emancipated suffering from the smallpox epidemic that raged across the South [4]. Decision-makers struggled because they wanted African Americans just healthy enough to return to plantation work, but not vigorous enough to be so whole and free as to upset the racial hierarchy that trapped them in a state of subservience [4, 5]. Mismanaged care contributed to the deaths of many of the 60,000 people who died in the outbreak [5].

We hypothesized that racist ideology took deeper root in regions with higher proportions of enslaved people, allowing systems of oppression and isolation to flourish long after the Emancipation Proclamation. We provide our own analysis exploring the relationship between the prevalence of slavery in North Carolina (1860) and present-day sociohealth outcomes. We expected to find correlations between the number of enslaved and various indicators, suggesting that while the formal institution of slavery was dissolved some 150 years ago, intentional forms of control stretched into the 20th century, blunting African American progress through policy designed to keep them disenfranchised, dependent, and unhealthy.

To test this hypothesis, we gathered slave population data from the 86 counties that comprised North Carolina in 1860 and matched 23 present-day sociohealth factors. We expected to find that counties with the largest proportions of enslaved peoples would be associated with more negative sociohealth outcomes in the present day. We chose factors from *preventable hospital stays* to *food insecurity*, based on the theoretical assumption that structural racism could impact the variance in these indicators [6]. Of these 23 factors, 16 reported statistically significant relationships with the county’s slave population, the strongest two, according to our analysis, being the intercorrelations with present-day *percent of African Americans per county* ( $r(84) = .79, P < .001$ ) and *food insecurity* ( $r(84) = .64, P < .001$ ) (Figure 1).

Electronically published May 4, 2020.

Address correspondence to William H. Munn, III, 224 South Dawson St, Raleigh, NC 27601 (will@ncjustice.org).

**NC Med J. 2020;81(3):198-200.** ©2020 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2020/81312

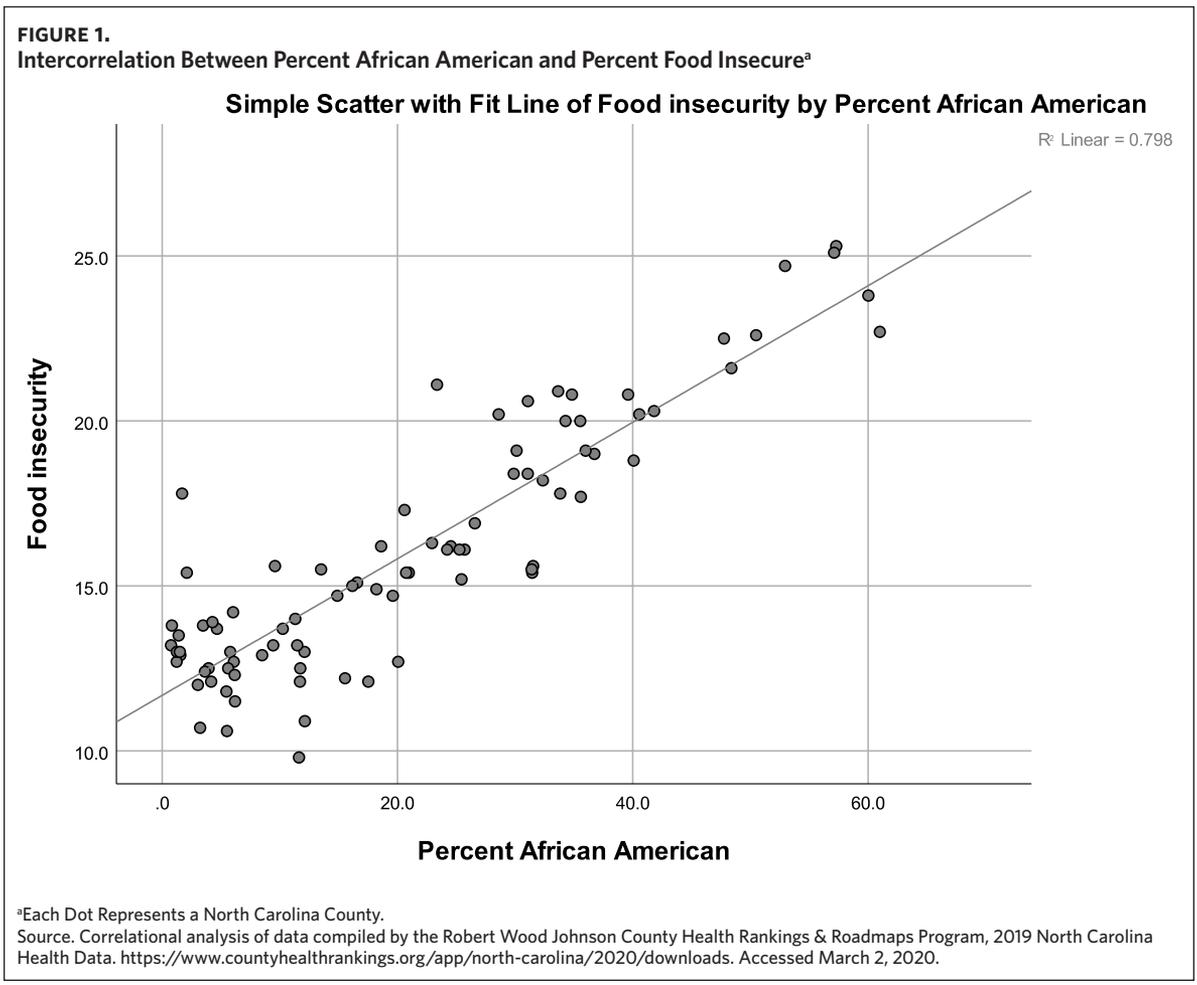
Our analysis of other variables in the model found that as the *share of enslaved* increased, so did *diabetes prevalence, preventable hospital stays, and cases of severe housing cost burden*. With the *percent of African Americans* so strongly correlating with *percent of county enslaved*, we ran a second correlational matrix between that variable and the other 22 sociohealth indicators. Percent African American per county had statistically significant relationships with 17 of the other 22 indicators, many with stronger effect sizes. Of note is the strength of the relationship between *food insecurity* and *percent African American* at  $.89$  ( $r(84) = .89$ ,  $P < .001$ ).

Given that such strong relationships exist between the presence of slavery and sociohealth outcomes, we argue the presence of modern-day health inequities is a collective, societal decision to maintain an ethnic hierarchy at the expense of people's quality of life. Modern policies such as Medicaid expansion would deliver benefits to communities traditionally marginalized. In fact, counties such as Martin, Robeson, and Duplin would see 14%, 11%, and 10% of their county populations, respectively, gain health insurance within three years of expansion [7] (Figure 2).

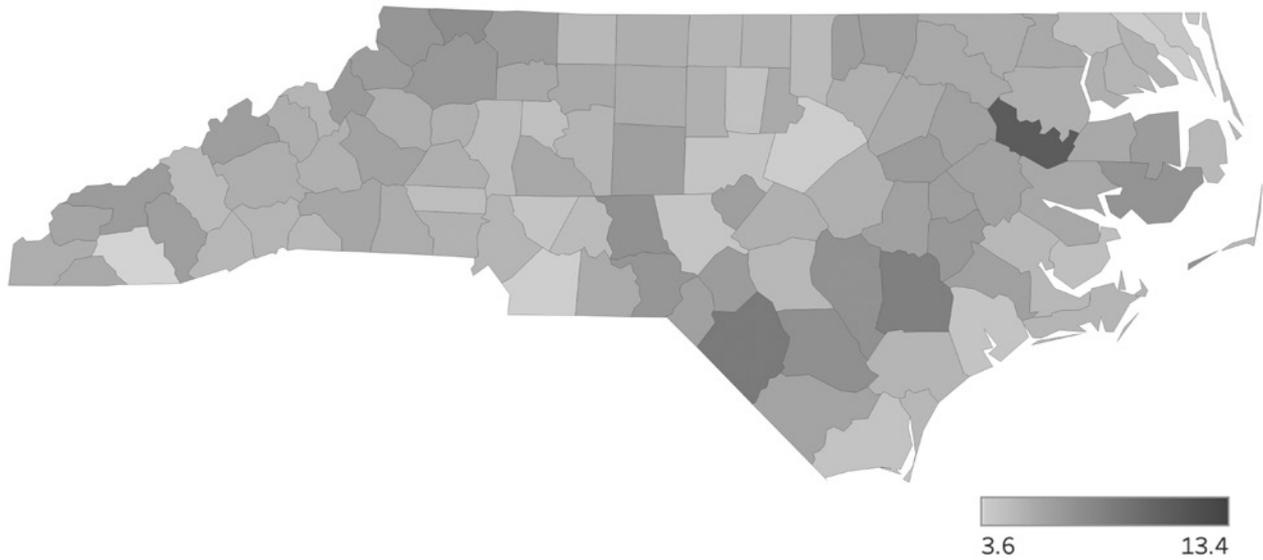
Additionally, there is a statistically significant, positive relationship between counties with larger nonwhite

populations and the number of people eligible for Medicaid expansion ( $r(98) = .36$ ,  $P = .001$ ) [8]. That is, counties with populations whose health has most likely been compromised by the weight of historical precedent stand to benefit most from Medicaid expansion.

This brief, correlative exploration seeks to simply draw some connections between the nature of present-day sociohealth outcomes and the prevalence of slavery in North Carolina, not argue causation. That said, it would be irresponsible to ignore the number and strength of the relationships revealed, particularly as we collectively work to address modern-day disparity. It is clear that the structures and systems in Southern US society have created and maintained an intentional dampening on the quality of life of African Americans, to include their health. While no one living today is directly responsible for the foundation of white supremacy, slavery, and residual forms of racialized control and oppression, we are all responsible for acknowledging present-day manifestations of this ideology and for correcting the impact of past destructive policy. This acknowledgment and subsequent embrace of restorative public policy will do much as a starting point to address health disparities defined by race and geography in North Carolina. Medicaid expansion is one such policy. NCMJ



**FIGURE 2.**  
**Percent of County Population That Gains Health Insurance With Medicaid Expansion**



Source: Ku L, Bruen B, Brantley E. The Economic and Employment Benefits of Expanding Medicaid in North Carolina: June 2019 Update. Washington, DC: Center for Health Policy Research, The George Washington University; 2019. <http://www.ncpolicywatch.com/wp-content/uploads/2019/06/Expanding-Medicaid-in-North-Carolina-final.pdf>. Accessed March 17, 2020.

**Nicole Dozier, BA** director, Health Advocacy Project, North Carolina Justice Center, Raleigh, North Carolina.

**William H. Munn, III, PhD** policy analyst, Health Advocacy Project, North Carolina Justice Center, Raleigh, North Carolina.

### Acknowledgments

We thank colleagues Rebecca Cerese and Hyun Namkoong for their contributions and input and Carlene McNulty and Suzy Khachatryan, and Julia Hawes for their review.

Potential conflicts of interest. The authors report no relevant conflicts of interest.

### References

1. Yearby R. Racial disparities in health status and access to health-care: the continuation of inequality in the United States due to structural racism. *Am J Econ Sociol.* 2018;77(3-4):1113-1152. doi: 10.1111/ajes.12230
2. Acharya A, Blackwell M, Sen M. *Deep Roots: How Slavery Still Shapes Southern Politics* Princeton, NJ: Princeton University Press; 2018.
3. Archarya A, Blackwell M, Sen M. The political legacy of American slavery. *J Polit.* 2016;78(3):621. <http://dx.doi.org/10.1086/686631>
4. Downs J. The Healing Power of Labor: Dependent, Disabled, Orphaned, Elderly, and Female Freed Slaves in the Postwar South. In: *Sick from Freedom: African-American Illness and Suffering during the Civil War and Reconstruction.* Oxford University Press; 2012:120-145. doi: 10.1093/acprof:osobl/9780199758722.003.0006
5. Schuessler J. Liberation as Death Sentence. *NYTimes.com.* <https://www.nytimes.com/2012/06/11/books/sick-from-freedom-by-jim-downs-about-freed-slaves.html>. Published June 10, 2012. Accessed March 3, 2020.
6. Robert Wood Johnson Foundation. North Carolina Rankings Data: 2019. County Health Rankings & Roadmaps website. <https://www.countyhealthrankings.org/app/north-carolina/2019/downloads>. Accessed March 2, 2020.
7. Ku L, Bruen B, Brantley E. The Economic and Employment Benefits of Expanding Medicaid in North Carolina: June 2019 Update. Washington, DC: Center for Health Policy Research, The George Washington University; 2019. <http://www.ncpolicywatch.com/wp-content/uploads/2019/06/Expanding-Medicaid-in-North-Carolina-final.pdf>. Accessed March 17, 2020.
8. Robert Wood Johnson Foundation. North Carolina Rankings Data: 2020. County Health Rankings & Roadmaps website. <https://www.countyhealthrankings.org/app/north-carolina/2020/downloads>. Accessed March 2, 2020.