Place Matters:
From Health and Health Care Disparities to Equity and Liberation

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Place—a confluence of the social, economic, political, physical, and built environments—is fundamental to our understanding of health and health inequities among marginalized racial groups in the United States. Moreover, racism, defined as a system of structuring opportunity and assigning value based on the social interpretation of how one looks (i.e., race), has shaped the places people live in North Carolina. This problem is deeply imbedded in all of our systems, from housing to health care, affecting the ability of every resident of the state to flourish and thrive.

The Greek physician and philosopher Hippocrates, from whom medical doctors take their Hippocratic Oath, is credited with saying, "Tell me what ails you, and I will tell you where you are from." Centuries later, renowned sociologist, activist, and writer W.E.B. DuBois combined ethnography, social history, and descriptive statistics in his groundbreaking study, *The Philadelphia Negro*, to document the stark inequalities in mortality shaped by the neighborhoods in which African Americans lived [1]. As these findings—and many empirical studies since then—have shown, where one lives is a fundamental structural driver of health and health inequities.

In the United States, "place" cannot be understood outside of structural racism. This is particularly true in the South, a region of the country deeply rooted in the history and legacy of slavery, the violent repression and disenfranchisement of African Americans vis-à-vis Jim Crow laws, and racial discrimination embedded in institutions that continues to this day. Thus, any dialogue about place mattering for health must be grounded in a serious conversation about how structural racism has created the places we live, and consider the implications this has for the racial and economic inequities we see in health outcomes. Here, I will focus my comments on how place matters for health at three levels: between regions in the United States, between counties within North Carolina, and between neighborhoods within cities across the state.

Racial Health Inequities in the South

For about 40 years, the Southern United States has been known as the stroke belt—a region of the country with the highest stroke mortality and striking racial inequalities [2]. African Americans between the ages of 45 and 54 die of strokes at a rate three times greater than that of their white counterparts [3]. Similar trends are found for obesity, coronary heart disease, type 2 diabetes, maternal and infant mortality, and a wide range of chronic diseases. For example, infant mortality rates are much higher in the US South, with Mississippi having the highest infant mortality rate: 8.73 per 1,000 live births [4]. This is more than double the rate for Massachusetts, the state with the lowest infant mortality rate (3.66 per 1,000 live births) [4]. North Carolina falls in between with an infant mortality rate of 7.1 per 1,000 live births, which is still significantly higher than the overall infant mortality rate for the country: 5.79 per 1,000 live births [4].

Some researchers erroneously attribute this regional phenomenon to "racial genetics" and poor health behaviors. But the disproportionate burden of disease in the South and the striking racial inequalities that exist cannot be understood without acknowledging the legacy of slavery and Jim Crow, the violent disenfranchisement of African Americans, and the continuation of regressive policies at state and local levels that limit the economic and social mobility of African Americans and other marginalized racial groups [5]. For example, this region of the country suffers from a weak health care safety net because of the decisions of many Southern states to opt out of Medicaid expansion. Of the 13 states in the South, nine have refused to expand Medicaid under the Affordable Care Act. They continue to do so despite the fact that failure to expand Medicaid has resulted in thousands of excess deaths, billions of dollars in lost revenue for states, and closure of rural hospitals, all of which have disproportionately impacted poor communities and communities of color. It's also worth noting that of these nine Southern states that have turned down Medicaid expansion, five of them— Alabama, Mississippi, South Carolina, Tennessee, Texas—also implemented restrictive

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election laws that have led to the political disenfranchisement of African American voters [5].

Beyond regional inequalities, geographic health inequalities persist within North Carolina as well. The state has its own so-called black belt, which consists of several counties located in the northeast region, where the proportion of African Americans has historically been the highest and health outcomes are the worst in the state [6]. For example, the Robert Wood Johnson Foundation's annual County Health Rankings rank counties along two dimensions: health outcomes and health factors. Health outcomes include length of life, measured by premature death (years of potential life lost before age 75) and quality of life, measured by self-reported health status (percent of people reporting poor or fair health and the number of physically and mentally unhealthy days within the last 30 days) and the percentage of low birth weight newborns. Health factors include health behaviors (tobacco use, diet and exercise, alcohol and drug use, sexual activity), clinical care (access to care, quality of care), social and economic factors (education, employment, income, family and social support, community safety), and the physical environment (air and water quality, housing and transit). The lowest-ranking counties (14 out of 25 in the bottom quartile) are consistently located in the northeast region of the state [7]. Health behaviors are often cited as the main drivers of poor health, but an individual's behavior is far from the only factor that contributes to poor health outcomes in the state. Social and structural drivers such as socioeconomic status, access to healthy foods, and employment overlay factors of geography to impact health, often along racial lines.

Drawing from my own personal experiences, the idea that place is fundamental to our understanding of the deeply entrenched racial inequalities in health was solidified for me in the city of Rocky Mount. Some readers may not know that driving on Highway 64 from Raleigh to Rocky Mount, there is a five- to six-year difference in life expectancy [8]. There are also striking inequalities that exist within the city itself. As a first-year student in the MPH program in the Department of Health Behavior and Health Education at the University of North Carolina, I was engaged in an "Action-Oriented Community Diagnosis," a process rooted in popular education methods that triangulates qualitative data from residents with local administrative data to identify the strengths and challenges in local communities, with the ultimate goal of mobilizing data for action. For the project, I was assigned to southeast Rocky Mount—a poor, predominantly African American community—and worked alongside two Black women who had been on the front lines of local organizing in the city for well over 20 years. Early in the process, we went to a set of train tracks that divided the town in two. One of the long-time pastors and activists told our group that, more than simply being a physical divide, these tracks were a tangible symbol of the racial, political, economic, and social divide in the city.

Rocky Mount is not alone in this. Durham has these divides. Chapel Hill has these divides. Greensboro has these divides. Across urban (and even rural) areas in the state, we see this kind of divide, and we know that it's not just about the separation of people, but also the separation of resources, and the economic disinvestment that has happened in these communities for decades. This leads me to the third reason place matters for health and health inequities: racial residential segregation.

Racial residential segregation in the United States is a form of structural racism that creates and maintains separate and unequal residential environments for African Americans and other marginalized racial groups [9]. Though discriminatory federal, state, and local laws and practices (e.g., redlining) that undergirded the creation of residential segregation were outlawed over 50 years ago by the Fair Housing Act of 1968 [10], together they remain one of the most pervasive and persistent hallmarks of urban areas across the United States. Decades of disinvestment in racially segregated neighborhoods have resulted in the clustering of a wide array of adverse exposures in these settings, including limited access to economic and educational opportunities, limited access to health-promoting resources, and exposure to a host of poor social conditions that predispose individuals to many behavioral, biological, and psychosocial precursors to poor health outcomes [11-13]. For example, this can be seen in the city of Durham, where the southeast corner of the city, where Lincoln Health System is located, remains disinvested to this day [14].

Suffice it to say that our dialogue around neighborhoods cannot be ahistorical; we cannot deny the ways in which institutional and structural racism have created separate and unequal living conditions for folks in our state and around the country. With all this in mind, I couch my research and the work that I do in a deep understanding of racial residential segregation. We cannot understand how place shapes health and health inequalities without understanding the ways in which federal, state, and local policies created the neighborhood environments in which we live today.

Finding Equity Through Policy

Understanding how these inequitable environments were created can help us determine the actions needed to recreate them in more equitable ways through policy interventions aimed at helping communities not only survive, but thrive. Effecting change will require examining existing policies—both within and outside of the health care system—that are driving these inequalities.

Change the Environment, Change the Outcomes

One of the symptoms of community disinvestment—and an important structural risk factor for poor health outcomes—is lack of access to healthy food. This gets a lot of policy and media attention, but it is only one of the many drivers of health that must be addressed at the local, state,

and national levels to move from health disparities to health equity. We must also work toward optimizing health care systems and investing in jobs and public education. We must focus on multisectoral policies that will build up communities in multiple domains in order to truly improve health and eliminate health inequalities.

For the past six years, I have done work in Jackson, Mississippi, with the Jackson Heart Study, a community-based cohort study examining the determinants of cardiovascular, renal, and respiratory diseases among African Americans. In that work, we use a spatial measure of residential segregation to examine inequalities in the incidence of cardiovascular disease and stroke over a 10-year period. What we have found is that in an all African American sample, there is a two-fold difference in the likelihood of having a stroke or heart attack between the most segregated neighborhoods and the least segregated neighborhoods in the city [15]. This suggests that structural factors rooted in racism, not race or biology, are the major drivers of poor health among African Americans, warranting the need for the kinds of multisectoral policies previously noted.

Building Healthy Communities

What does policy change look like in practice? Starting in 2010, the California Endowment launched a Building Healthy Communities Initiative (BHCI) [16]. BHCI focused on the idea that zip code is more important than genetic code in determining health, from a grassroots and community organizing perspective. The initiative has three tenets:

Building power in local communities. BHCI works to arm community members to identify and advocate for the policies necessary to change outcomes. This helps lead not just to capacity, but to power—both economic and political. The changes and the transformation required for equity in health and other areas will necessitate fundamental changes to local communities

Supporting policy and systems changes. BHCI helps identify the set of policies, both within the health care system and outside of it, that optimize health in local communities. Expanding Medicaid is one example; creating better health care systems is another. But we must also think about how we are improving education, how we make sure displacement is not the unintended consequence of progress, and how we develop new, better communities where everyone benefits from these changes. This is system change. When thinking about increasing access to healthy foods, for example, we have to think about food access as a part of a system. We must imagine how we not only change access to healthy foods, but also the other types of investment necessary in those communities.

Improving opportunity environments. BHCI's third tenet involves identifying and improving opportunities for children and adults to live the healthiest lives possible. This is where the grassroots work of addressing social drivers of health comes in.

The public health field is getting more comfortable talking about equality, and increasingly equity. Now we must move forward toward liberation, and think hard about how we liberate communities to be able to not only survive, but to thrive. As Dr. Mary Bassett, former commissioner of the New York Health Department, has said: "We must name racism" as a cause of poor health, because how we frame a problem is inextricable from how we solve it [17]. In the state of North Carolina, where I'm happy to have been born and raised, we must address this issue head-on if we're going to move toward health equity.

Systemic Racism Requires Systemic Change

Physician and epidemiologist Camara Phyllis Jones often defines racism as a system that "unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources" [18].

If, as a state, we are going to move toward health equity, we must get over our collective discomfort of the term "racism." We must acknowledge that it exists, and work toward eradicating it and dismantling it in all of its forms.

Recently, I attended a talk at Greenleaf Christian Church in Goldsboro by Ibram Kendi, author of the book *How to Be an Antiracist.* Dr. Kendi talks about racism in our country and in our state as being a cancer. He said, and I am paraphrasing, "When you find out you have a diagnosis of cancer, you're scared. You don't want to deal with it; you really don't want to confront it. But if you don't actually deal with the cancer, it will kill you." That's what we are seeing in our health outcomes; we're seeing it in the ways that we are not thriving as a state and as a nation. We must deal with the issue of racism to move the needle toward equity, and toward liberation, to improve the health outcomes of everyone in North Carolina. NCMJ

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