CHAPTER XXVII
THE SOCIO-ECONOMIC BACKGROUND
OF NEGRO HEALTH STATUS

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The health status of a people is determined not only by inherent capacity to survive but also by the influence of the cultural milieu. Biology and environment are so interrelated in determining health status that it is hardly possible or practicable to attempt a separation. Viewed from this perspective, the health status of the Negro becomes more than a question of medicine, or of hospitals, or of physicians. It is bound up securely with the elusive factors of economic levels, cultural status, and the progress of medical science itself. The health status of the Negro cannot be adequately understood without reference to the socio-economic context of the group. There is a significant correspondence between the amount of Negro illiteracy, low economic status, and morbidity and mortality rates. Folk cures, superstitions, and lack of knowledge throw up a formidable barrier to proper treatment of illness.

INCOME, OCCUPATIONS AND HEALTH STATUS

Quite apart from the external restrictions with respect to admission to hospitals and full participation in various public health programs, the Negro faces serious economic handicaps. The significance of economic well-being as a factor in disease prevalence has been widely studied. It is rather generally accepted that mortality and morbidity rates are higher among the poor than among the relatively well-to-do. Poverty itself is not a causative factor in ill-health, but it is the inability due to inadequate income to maintain a standard of living conducive to good health which is the important factor. The best index of economic status is obviously the income of a group. The income of the Negro shows a great disparity when compared with that of other groups in the population. In 1946, for example, the median income of urban and rural nonfarm nonwhite families in the United States was $1,562 as compared with $2,741 for whites.\(^3\) The median income of white families ranged from $2,441 in the South to $2,970 in the Northeastern states while that for nonwhites ranged from $1,318 in the South to $2,059 in the North Central States.

Occupation not only plays a determining rôle in fixing income but it is also one of the most potent factors in deciding the state of health and fixing the length of life.\(^2\) The hazards of accident and disability vary significantly for occupations. Work activity itself involving hard physical labor appears to have a deleterious effect on health. The im-


importance of occupations in affecting health status can be noted in the fact that states with widely differing occupational characteristics show marked difference in mortality rates. In general, industrial states have higher death rates than agricultural states and unskilled industrial workers have approximately twice the death rate of white-collar workers. This latter circumstance has significant implications for the health of Negroes.

Prior to the recent war, the heaviest concentrations of Negro workers were in unskilled branches of industry, and in agriculture and domestic and personal service, although there had been some penetration into industry and into positions above the unskilled level. In 1930, there were 64 general industrial or service groups in a total of 126 in which Negro workers were engaged and in which 50 per cent or more were unskilled and 50 per cent or more of the white workers were above the unskilled level. As a matter of fact, the total number of Negro workers in the 64 fields was 3,051,408 or 55.4 per cent of the total Negro working population. About two-thirds of these workers were in agriculture and domestic and personal service.

There were, however, 38 industrial fields in which 50 per cent or more of the Negroes were employed in capacities above unskilled labor. In these industries were 665,834 Negro workers or about 12 per cent of the total working force. In only seven occupational fields were more than 50 per cent of the Negro employees skilled or white collar workers. These fields were: suit, coat and overall factories; automobile repair shops; post-
al service; insurance; real estate; professional service; recreation and amusement.

Despite the fact that Negroes made tremendous industrial and occupational gains as a result of World War II, their relative position in the total labor force did not change substantially. There was little change in the proportion occupied in unskilled jobs, for while there was some upgrading of Negro workers, a larger number of Negroes was added to the labor force in the lower job classifications. Between 1940 and 1944, Negroes made gains as skilled and semi-skilled workers, but over 98 per cent of the clerical and sales force in the country and approximately 95 per cent of the professional, proprietary and management group remained white between 1940 and 1944.

The recent war did have, however, an important bearing upon the future of Negro labor. First, Negro workers were geographically distributed where the bulk of war industries were located. In the first monumental plans for war production in 1941 the value of defense contracts and project orders was $13,287,163,000, and of this total the fourteen Southern states received about 7 per cent, although they had about a fourth of the population. This means that the vast bulk of these contracts went to states outside the South. The war contracts were awarded to the older industrial areas where there were basic facilities, transportation, and a potential labor force reasonably well adapted to industry. For the period June 1940 to

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June 1942, 6.3 per cent of the $80 billion in war contracts went to eleven Southern states. Eight Northern and Western states received over half the awards, and these states drew Negro labor to them. This undoubtedly will have permanent effects upon the geographic and industrial distribution of the Negro population, despite the incidence of new industries in the South. This has significant implications for the health status of the Negro not only with reference to the changes in income status involved, but also with reference to the modification of working conditions which have been observed to affect health status in some measure.

Housing and Health Status

Inadequate housing is another aspect of general Negro life which is associated with low income and poor health status. In every major American city, the pattern of population distribution provides residence areas that are either predominantly or exclusively Negro in tenure. Whatever the character of the general population, even in the cities, of the North and West where there are several cultural and national groups, the Negro districts stand out boldly and few Negroes may live outside of them. There are certain characteristics almost invariably associated with the Negro residence area. These areas tend to be located in the oldest part of the city, where the first housing was erected, and thus they contain the oldest and most obsolete dwellings. This has also been generally true of the areas of concentration of other newly arrived immigrant groups, such as the Little Italys and Little Bohemias of many Northern cities, now tending to disappear because of restrictions of foreign immigration. The difference has been that with improved economic standing and "Americanization" significant numbers of the members of European nationality groups have been able to move into areas of better housing and greater dispersion. Negroes whose economic status and adjustment to new ways of living have shown similar progress have frequently been unable to move out in the same way.

The Negro areas tend to exhibit the greatest municipal neglect, not only because the dwellings and surrounding facilities are hardest to keep in repair but also because the residents themselves frequently have little voice in the municipal government. The result is that these areas afford least protection from fire hazards, least enforcement of health and sanitary codes, and smallest attention to the collection of rubbish and garbage and to the repair and upkeep of streets and alleys.

Most of the structures in Negro residential areas are owned by persons other than the occupants and are kept for rental purposes. Because the properties often lack modern conveniences and have been rejected by successive economic levels of white residents with freedom to move to more desirable areas, the over-all rent levels tend to be low. However, when compared with similar accommodations available to white tenants the rents are generally high. Shuman found from an examination of 1940 census data for Newark, New Jersey, that when rent as a factor was held constant, Negro housing was greatly in-
ferior to the dwellings occupied by white families. She found that on every rent level, the percentage of substandard Negro housing was considerably greater than the percentage of substandard white units, and that the differential against Negro housing was greater at higher rent levels. Robinson, in a more extensive investigation, used 1940 census data to study the relationship between the condition of dwelling units and rental value by race of occupants in 16 Northern and Western cities and 26 Southern metropolitan districts. She concluded that the nonwhite group received proportionately less housing value for the same price than did the white group.

Segregated residential areas not only facilitate differentials in rent and in municipal services by race but also make possible, as an incidental factor, differentials in other living costs such as food prices. The Commissioner of Public Welfare in Chicago testified before a General Conference called by the Mayor's Committee on Human Relations, that food prices in the Negro residential areas were the highest in the city.

In the South, where the bulk of the Negro population resides, migration of Negroes to the cities and outside of the region has not improved the housing situation for Negroes of the region. Between 1940 and 1947, the Negro population in the Southern states decreased in round numbers from 10,007,000 to 9,550,000, a decline of 4.8 per cent. During the same period, however, the proportion of decrease in the dwelling units occupied by Negroes was 6.8 per cent which exceeds the proportion of Negro population loss. Although the Negro population in the South declined during and since the war, the number of Negroes living in Southern urban centers actually increased by over 600,000 persons. While this represented a population growth of 16.5 per cent, the number of urban dwelling units occupied by Negroes in the South grew by only 13.8 per cent.

Negro families, as their numbers increased, have been forced to increase the ratio of persons to living space. In the 17 Southern and border states in 1940, approximately 10 per cent of the urban dwelling units occupied by Negro owners housed more than 1.5 persons per room, as against less than 5 per cent in the case of such units occupied by white owners. With regard to urban tenants, 23.0 per cent of the dwelling units occupied by Negroes housed more than 1.5 persons per room, while only 12.3 per cent of the urban dwellings occupied by white tenants were similarly overcrowded.

Even if Negroes were free to compete for more adequate housing on the same basis as whites in the open market, the lower incomes of Negroes would still place them at a disadvantage. Income limitations partly explain the fact that 52.5 per cent of the urban dwellings owned by Negro families were under $1,000, while

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only 12.2 per cent of the urban units owned by whites fell in this class. Barely 14 per cent of the dwelling units owned by Negroes exceeded $5,000 in value, as against over 60 per cent of the units owned by whites.8

The situation with respect to rural housing in the South is seriously inadequate for both whites and Negroes, but is more critical for Negroes than for whites. The following comparison of housing characteristics of rural farm dwellings occupied by whites and nonwhites in the South in 1940 indicates some of the critical aspects:

Low income, high rents, overcrowding and inadequate facilities for the maintenance of proper sanitary standards form a complex of factors relating to Negro housing which aid in explaining its association with high mortality and sickness rates among this racial group.

ILLITERACY AND SUPERSTITION

The placing of major emphasis upon the relationship of economic factors to health status is not intended to minimize the role of other measures in determining the health status of the Negro. One of the most acute problems is that of illiteracy and superstition. Education in proper health measures faces serious handicap where there is an absence of literacy. Illiteracy in the United States had declined to a new low by October, 1947, at which time only 2.7 per cent of the population 14 years old and over were unable to read and write.9 However, the illiteracy rates for whites 14 years old and over was 1.8 per cent as compared to 11.0 per cent, or 6 times as high, for nonwhites. Marked progress in the reduction of illiteracy among nonwhites is indicated, however, by the relationship of illiteracy to age in this group. (See Table II.) The proportion of illiterates was lower in each successively younger age group. Although 32 per cent of the nonwhites 65 years old and over were illiterate only 4 per cent of the nonwhites 14 to 24 years old were illiterate.

Illiteracy is intimately related to ignorance about the nature of disease, the seriousness of disease, and the manner of promoting health. Whiting, in a study of 50 patients of relatively low educational status, found that 15 or approximately one-third of the patients had problems of cultural adjustment associated with their diseases which constituted a hindrance to the successful utilization of modern and accepted medical practices.10 Whiting cites a case of an uneducated widow, sixty years of age, which illustrates the manner in which individual practices and traits, representative of a cultural lag, may enter into or constitute a medical problem:

The patient blamed her illness on the fact that she had been “hoodoed”, and because of this she felt that there was no possible medical cure for her. According to her system of beliefs, only the person responsible for the “hoodo” spell could break it. According to her story, she had been “hoodoed” twice and both of the agents were dead; consequently her situation was hopeless. She was “crossed-up”, as she termed it, first, as a child when a neighbor accidentally threw “snake-dust” on her. The second “crossing-up” was blamed on her sister-in-law, who she claimed,
TABLE I

COMPARISON OF HOUSING CHARACTERISTICS OF RURAL FARM DWELLINGS OCCUPIED BY WHITE AND NONWHITES IN THE SOUTH: 1940

<table>
<thead>
<tr>
<th>Housing Characteristics</th>
<th>Color of Occupants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>Per Cent Needing Major Repairs</td>
<td>36</td>
</tr>
<tr>
<td>Percent Without Running Water</td>
<td>89</td>
</tr>
<tr>
<td>Percent Lacking Electricity</td>
<td>78</td>
</tr>
<tr>
<td>Per Cent Lacking any Water Supply</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: Southern Regional Council, The Condition of Our Rights, Atlanta, 1948, p. 32.

TABLE II

PER CENT ILLITERATE IN THE CIVILIAN NONINSTITUTIONAL POPULATION 14 YEARS OLD AND OVER, BY AGE AND COLOR, FOR THE UNITED STATES: OCTOBER, 1947.

<table>
<thead>
<tr>
<th>Age</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>White</td>
</tr>
<tr>
<td>Total, 14 years and over</td>
<td>1.8</td>
</tr>
<tr>
<td>14 to 24 years</td>
<td>0.6</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>0.8</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>1.3</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>2.0</td>
</tr>
<tr>
<td>55 to 64 years</td>
<td>4.2</td>
</tr>
<tr>
<td>65 years and over</td>
<td>4.9</td>
</tr>
</tbody>
</table>

constantly attempted to alienate her husband’s affections. In regard to the method used to “cross her up,” the patient explained that the sister-in-law was her hairdresser, and that she simply plucked several hairs from her head and subjected them to certain “hoo-dooistic” rituals. As a result the patient felt that medical treatment would be too avail, and often asked the doctors to give her enough ether so that she could die quietly.11

The use of folk or hear-say remedies or patent medicines is related both to lack of education and to low income. Price, in a study of Negro infant mortality in Nashville, found that 60.0 per cent of 146 Negro mothers reported that they used folk or hear-say remedies or patent medicines in treating illnesses.12 Forty or 27.0 per cent of the mothers stated that they used folk or hear-say remedies. The relationship to education is seen in the fact that none of the mothers who reported 12 or more years of schooling reported using hear-say remedies and only a few such mothers reported use of patent medicines. Price also discovered that mothers who used hear-say remedies were more likely to be of rural birth than mothers who did not use such remedies.13

Health education and health programs have increasingly been having their effects among the Negro population; Negro illiteracy has been reduced markedly; migration of Negroes from the South to the North and West has exposed them to better wages and certain measures of sanitation; and along with these factors has gone a consistent improvement in health. Negro mortality rates today are approximately where the white rates were about 20 years ago; and where conditions are at all favorable, simi-

11 Ibid., p. 54.
lar results are registered in life conserva-

**CONCLUSION**

Dorothy Dickins has elaborated a health program for the improvement of health in the South which combines science, economics and education, implemented by community responsibility. She suggests the following measures: (1) complete elimination of malaria, hookworm and pellagra, three diseases peculiar to the South; (2) improvement of the diet of Southern people; (3) an increase in income, and (4) programs of health education for the entire population.\(^1\)

There is wisdom in her insistence that the adoption of these measures should be a matter of community responsibility.

It is necessary, from the perspective of socio-economic factors, to view Negro health problems as community or social problems rather than as personal or racial ones before the necessity for improvement can become fully convincing. Eventually the community pays for Negro ill-health. It pays not alone through taxes for public health and relief programs, but for the support of institutions, and for the loss of a healthy citizenry. It pays in philanthropy and the personal aid doled out to the individual Negro indigents which many of the white families of the South and of the nation find it difficult to escape. The community further pays in the loss of both a producer and a consumer in the shortened span of the Negro's life. For at the present mortality rate they are cut off before the community can fully compensate itself for the expense of rearing them to the age of self-support.

Death rates, however, reveal only the annual loss of human lives. For each death there are about 16 illnesses lasting for one week or longer that involve loss of work for the family breadwinner, inability of the housewife to go about her normal duties, or absence from school of the school child.\(^2\) This indicates a burden of disability which the community sustains and which might well be reduced or eliminated through the application of our present knowledge of science and social engineering to the socio-economic factors associated with health status.

\(^1\)Dorothy Dinken, "Health in Relation to Prosperity in the South," *Journal of Farm Economics*, 30:371, 36, 1938.