Analyzing Life Histories: Exploring Healthcare Disparities in the SLHC

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Engl 482: Rhetoric of Digital Humanities

Word Count: 2,195

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December 9, 2024

Introduction

The Federal Writers' Project Southern Life Histories Collection (SLHC) is a rich compilation of personal narratives collected during the 1930s that provides a glimpse into the lives of individuals living in the Southern United States. The SLHC section seeked to document the culture and capture the experiences and struggles of Southerners, and offered invaluable insights into the social, economic, and cultural dynamics of the era.

Within this broader context, my analysis centers on disparities in access to healthcare amongst interviewees in North Carolina. The 1930s marked a time when healthcare systems in the United States were underdeveloped and unevenly distributed, with access often determined by factors such as race and economic status. These narratives reveal how systemic inequalities and regional influences intersected to create significant barriers in healthcare access, particularly for Black individuals.

To investigate this topic, I utilized digital humanities methods, which allowed for a comprehensive analysis of the SLHC. Metadata analysis provided a structured way to examine patterns across interviewees, while data visualization tools such as Tableau and Voyant enabled the representation of key trends in healthcare access, race, and socioeconomic status. This led me to the conclusion that the Southern Life Histories Collection reveals stark disparities in access to healthcare among interviewees in North Carolina during the 1930s, underscoring how the intersectionality of race and socioeconomic status shaped individuals' access to healthcare.

Background

The Federal Writers' Project (FWP), created in 1935 as part of President Roosevelt's New Deal, provided employment for those affected by the Great Depression while documenting the

experiences of Americans, especially marginalized groups in this time period (States, 2022).

African Americans, hit hardest by the Depression, faced high unemployment, poverty, and racial

violence, with unemployment reaching nearly 50% by 1932 (Libguides-U.S.History, 2022). In

the South, where segregation and Jim Crow laws were deeply engraved, the situation was even

more dire. Racial violence surged, with lynchings rising from 8 in 1932 to 28 in 1933, turning

into a scapegoat ritual (Libguides-U.S.History, 2022). These stories, often suppressed, found a

voice through the Life Histories Collection, with the Southern Life Histories Project (SLHP)

focusing on the South to preserve the lived realities of African Americans, women, and the

working poor, addressing gaps in mainstream history.

      Critics of the SLHP have pointed out that the voices of marginalized groups were often

"mediated" through the perspectives of interviewers, raising concerns about authenticity,

representation, and accuracy (States, 2022). This becomes particularly important when analyzing

healthcare disparities, as these narratives offer first-person accounts of how individuals

experienced healthcare access. However, the perspectives of Black interviewees may have been

reframed by White interviewers, who have altered language, tone, or their framing of questions.

This can be seen as White interviewees often referenced "doctors" and "hospitals," while Black

interviewees typically described healthcare in terms of unmet needs and barriers (States, 2022).

These distinctions reflect the racialized nature of access in the 1930s, reinforcing the argument

that healthcare access was deeply shaped by race.

      A powerful example of these healthcare disparities comes from the SLHP narrative

"Reckin' I'll Be Washin' an Ironin' Till I Drop Daid," which tells the narrative of a Black woman

who has spent the past 40 years washing clothes for a living. Her story illustrates how

inaccessible healthcare shaped the experiences of Black families during the Great Depression.

She shares the heartbreaking story of her husband, Ed, who died from pneumonia. When he fell ill, a doctor refused to come without upfront payment, which they couldn't afford. Left with no choice, she cared for him using home remedies and following medical advice given later by a doctor she could only afford after borrowing two dollars from a neighbor. Despite this, Ed died overnight, and she went back to work to pay his burial fees. Her two daughters also died after prolonged illnesses, forcing her to bear the financial burden of their funerals, as well.

The woman's reflections on these experiences emphasize how Black families bore the brunt of medical costs, burial expenses, and the emotional grief associated with repeated loss. This experience led to her determination to maintain payments on an insurance policy to "have enough insurance to give me a decent buryin' when I die" so her other children would not have to be responsible for it (Folder 274, pg. 5). Her narrative, amongst many others carrying similar burdens, highlights the emotional, physical, and financial toll that healthcare disparities placed on Black families and reflects the compounding impact of healthcare inequality.

Healthcare disparities during the Great Depression were shaped not only by race but also by socioeconomic status, with marginalized communities, particularly African Americans and poor white Southerners, facing significant barriers to accessing medical care. Hospitals and clinics often refused to treat Black patients, and when they did, held harmful stereotypes such as the belief that Black individuals had a higher tolerance for pain, leading to the dismissal of their healthcare needs. Black patients were frequently denied essential treatments, like painkillers, and their pain was often disregarded (Hostetter & Klein, 2021). These conditions are reflected in the SLHP interviews, where Black narratives referenced reliance on home remedies, midwives, and community-based care networks, while white interviewees were more likely to mention formal medical care, reinforcing the divide in access and quality of healthcare.

Methods

      In order to process the data from the North Carolina life histories that the information is strived from, we, as a research group, created a corpus of 132 listed life histories. Each member of the class was responsible for their selected six life histories. We created a metadata schema, where we looked at demographics, narratives, and contextualization of the information presented. Then in order to quantify that information and turn it into usable metadata, we answered a list of questions that were deemed useful, to the point where if that piece was missing, we would feel a gap in that person's story. Putting all this information into a spreadsheet, we could now see all of our interviewees life stories in front of our eyes. This was then converted into a file to be imported onto tableau, a data visualization tool and platform used to depict our graphs. On this platform, we created tables of relationships between the main labels to see where there is correlational impact, as in the WHY of this time in history. This led to the creation of the three charts depicted in this paper, which exemplify the statement that the racial and economic backgrounds of interviewees significantly influenced their access to healthcare, depending on the region in which they resided.

Data Visualization

      Figure I compares the racial composition of individuals across different socioeconomic levels. About 41.67% of Black interviewees were Low-Income, versus 31.75% of White. The percentage evens out in the Lower Middle Class, where around 36% of the White population and Black populations were listed. The gap widens once again when 28.57% of White people are in the middle class, versus only 26.67% of the Black population. However, there is a similarity once

again, when White High class individuals consisted of 3.17% of the population, and Black High class was 5.56% of theirs.

Figure II shows the distribution of healthcare access by race—more specifically whether or not they were able to access it. Among White interviewees, 73.44% reported having access to healthcare, while 26.56% did not. For Black interviewees, 39.47% reported having access to healthcare, and 60.53% did not.

Figure III presents a text analysis of health-related terms within the Southern Life Histories Collection based on White narratives. The chart shows the relative frequencies of terms such as "sick" and "health" across document segments. The term "help" appears most frequently, with notable peaks in segments 3, 7, and 9, while "sick" and "health" also show consistent mentions, peaking in segments 2, 7, and 9. The term "die" has the lowest frequency overall, with small peaks in segments 4 and 8. These frequencies vary over the segments and provide insight into how health-related concepts are mentioned and distributed across the narratives, though the figure does not differentiate these frequencies by socioeconomic status.

Figure IV illustrates the relative frequency of terms related to healthcare across document segments for Black interviewees. The term "help" appears most prominently, peaking in several segments, particularly in 5, 7, and 10. "Health" also shows significant relative frequency, with peaks around segments 4, 5, and 9. The term "hospital" is used less frequently overall but sees notable peaks in segments 6 and 9. "Sickness," "medicine," and "doctor" appear with relatively low frequency, with minor peaks scattered across different segments. The overall trends suggest a greater emphasis on informal care ("help") and health-related concerns ("health") compared to institutional care ("hospital" and "doctor").
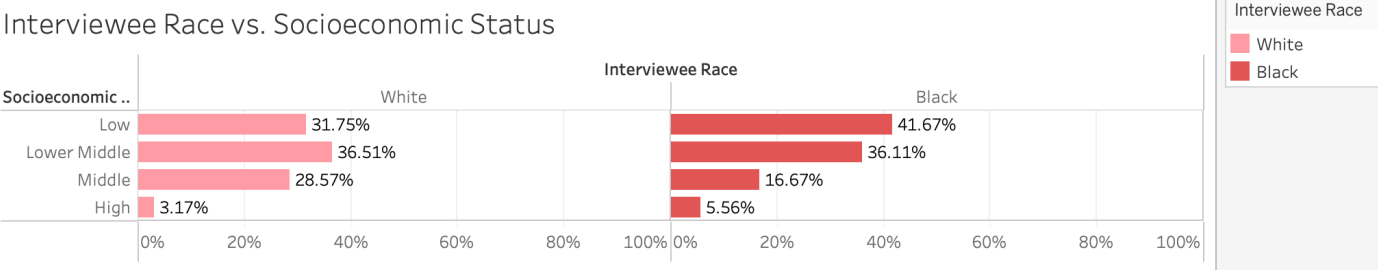
Figure I.

Interviewee Race vs. Socioeconomic Status

Interviewee Race

Socioeconomic ..	White	Black
Low	31.75%	41.67%
Lower Middle	36.51%	36.11%
Middle	28.57%	16.67%
High	3.17%	5.56%

Interviewee Race
- White
- Black

Figure II.

Interviewee Race vs. Access to Healthcare

Interviewe..	Access to healthcare
White	yes 73.44% / no 26.56%
Black	yes 39.47% / no 60.53%

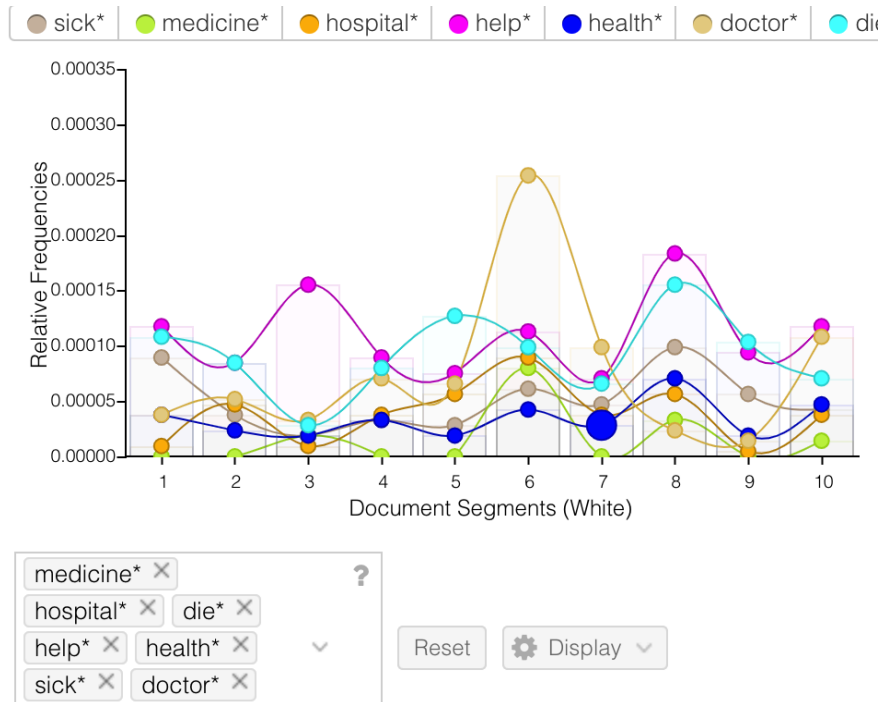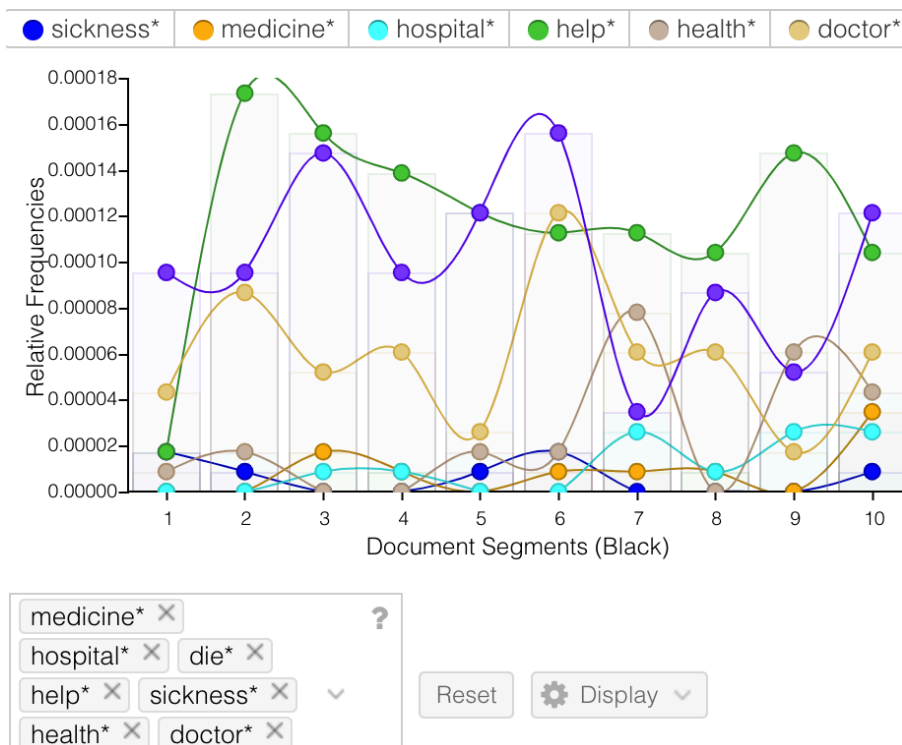Interviewee Race
- White
- Black

Figure III.

Figure IV.

Discussion

Intersection of Race, Class, and Healthcare Access

The narratives within the SLHP further reveal how race and class intersected to shape healthcare access. Black interviewees were disproportionately represented in lower socioeconomic categories, as shown in Figure I, which placed them in a position of economic disadvantage that worsened their ability to access healthcare. Similarly, the data in Figure II shows that a majority (60.53%) of Black interviewees lacked access to healthcare, and Figure IV further emphasizes that Black interviewees used language that reflects a lack of engagement with formal medical care. In fact, Black families often had to rely on informal care options due to the inability to afford upfront payments demanded by doctors, as seen in the stories of Black interviewees like the one in "Reckin' I'll Be Washin' an Ironin' Till I Drop Daid." This particular narrative demonstrates the challenges of racism and economic barriers, as the narrator's husband died after being unable to get proper medical care due to financial constraints (Folder 274, pg. 5). These patterns reflect how discrimination and exclusion from healthcare systems had long-lasting effects on both the health and economic well-being of Black families.

In contrast, White families, even those in lower socioeconomic categories, were more likely to access formal healthcare, a distinction reflected in Figures III vs. IV. White interviewees frequently used terms like "hospital," "doctor," and "health," indicating that they had more regular interactions with institutionalized medical care. For Black families, the reliance on terms like "help," "sickness," and "medicine," as seen in Figure IV, further illustrates the reliance on community-based or informal care practices due to systemic exclusion. These linguistic patterns point to the underlying issue of racial discrimination that systematically excluded Black families from mainstream healthcare networks, regardless of their economic standing.

Racial and Socioeconomic Disparities in Healthcare Access

The data reveals stark disparities in how different racial and socioeconomic groups experienced healthcare, with systemic discrimination playing a pivotal role. Figure I illustrates the racial composition across various socioeconomic categories, where Black individuals were more heavily concentrated in the lower socioeconomic strata. However, the figures also show that race was a more significant factor than socioeconomic status in determining healthcare access. While 73.44% of White interviewees reported having access to healthcare in Figure II, only 39.47% of Black interviewees had the same access, with a notable 60.53% excluded from receiving medical care.

This significant gap cannot be attributed solely to economic factors, as Figure I also displays that 5.56% of the Black interviewees were in the high socioeconomic category, compared to 3.17 % of the White population counterpart. In the theory of wealth, they should have higher access percentages, however, racial differences in healthcare access persisted, with Black individuals still experiencing limited healthcare options despite their higher socioeconomic status. This comparison highlights how racial discrimination and segregation within healthcare systems compounded the challenges faced by Black families.

While socioeconomic status did influence access to healthcare, racial exclusion in medical institutions created a barrier that was difficult to overcome, even for Black families in higher economic brackets. This points to the conclusion that systemic racism, rather than just poverty, was a critical determinant in healthcare access.

Conclusion

The research displays that access to healthcare in 1930s North Carolina was shaped by complex factors including race and socioeconomic status. The intersectionality of these factors led to significant disparities in healthcare access, particularly for Black and low-income individuals.

Further research could explore the specific mechanisms by which race and class influenced healthcare access in relation to their region of residence. This could include specific terms of access to medical facilities, racial segregation in healthcare settings, and the accessibility of trained healthcare providers across the piedmont, mountainous, or coastal areas of North Carolina. Another interesting angle to explore would be the intersectionality of household size or the amount of people in a particular family in comparison to their particular socioeconomic group, as the wealth class may change in specificity to household income level vs outgoing expenses. This could then be connected to either inaccessibility to healthcare or inequalities, in relation to overlaying disparities.

In all, the findings derived from the North Carolina section of the Federal Writers' Project Southern Life Histories Collection (SLHC) highlight the importance of considering multiple viewpoints based on varied social classes and barriers when studying the trends of healthcare disparities throughout our nation's history.

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