Political Participation in the Least Healthy Place in America: Examining the Political Determinants of Health in the Mississippi Delta

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Abstract

Context: Scholars have called on public health to more commonly and more effectively learn from political science to understand the political determinants of health.They argue that policy decisions affecting health cannot be understood without appreciating the political dynamics shaping key institutions. As the least healthy place in the United States, the Mississippi Delta provides valuable insights on the connections between power, political participation, and health.

Methods: This case study relies on historical analysis, a review of the literature, and descriptive analysis of a unique data set examining every law introduced in the Mississippi legislature during the 2017 legislative session.

Findings: Legislators from the Delta have comparatively little influence in state-level policy making in Mississippi. This lack of power has deep historical roots but persists today.

Conclusions: This examination of power in the Mississippi Delta raises questions about the ability of the political process to achieve health equity. Systemic barriers to power, including structural racism, suggest that policies which would advance health equity cannot happen without the support of white residents,particularly those living in other parts of the state. In other words, health equity is not likely to be achieved without buy-in from leaders outside the area with the greatest need.

Keywords political determinants of health, representation, health equity, state politics, the South

The Mississippi Delta is arguably the least healthy place in the United States. It is certainly the least healthy region in the least healthy state. Mississippi ranks 49th or 50th in such health outcomes as infant mortality, childhood obesity, diabetes deaths, and heart disease (Kaiser Family Foundation 2018). Outcomes in the Delta for many of these and other

Journal of Health Politics, Policy and Law, Vol. 44, No. 3, June 2019
DOI 10.1215/03616878-7367048 © 2019 by Duke University Press

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measures are on par with those in developing countries. That this level of poor health exists within our country is a crisis deserving our full attention.

Understanding the Mississippi Delta is critically important because, although the problems here are particularly acute, they are not unique. The extremes of the Delta help us see more clearly the complex relationships among class, race, and health that make achieving health equity across the nation so difficult. We should not emerge from a focus on the delta feeling good about how much better our home region or state is doing but awake to the inequities that exist around us.

The Delta serves as a valuable case study of the relationships among power, political participation, and health. I began to more fully appreciate these connections while conducting research for a separate project in the region. I asked focus group participants to describe the barriers they face to better health and steps they could take to improve the social determinants of health, such as housing and education. I expected to hear some discussion of the importance of voting, particularly given the region's deep history of fighting for enfranchisement. Instead, I heard cynicism about the political process as people said their votes would not matter. Many said they do not see policy making as a viable mechanism to improving health in the region, given this power imbalance.

One of the most intriguing aspects of the political dynamic in the Delta is that the candidates these residents likely would have voted for do go on to win, at least locally. The Delta is one of the most solidly blue pockets across the deep red South, meaning that their votes likely would not have changed the outcome of the election. However, this is not to say that residents of the Delta are being heard in policy decisions, particularly at the state level. The region votes for Democrats who either go on to lose statewide elections or are ineffective at driving policy change in the legislature because they are outnumbered by Republicans from other parts of the state. City and county leaders are limited in their ability to address structural issues, given legal and funding barriers imposed by the state. The situation in the Delta is the inverse of that in Kansas and Kentucky, where poor people are said to be voting against what is best for them (Frank 2004; Wright and Vanderford 2017). In the Mississippi Delta, voters do act consistently with their supposed economic self-interest by choosing leaders who support social programs designed to help poor people like them, but it does not seem to matter.

These issues epitomize the importance of more fully incorporating a political science perspective into our understanding of health. In particular, the Delta raises important questions about the conditions under which we can reasonably expect political participation to be a means to achieving

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policy goals such as improving health equity. Why vote or mobilize if the balance of power in Mississippi politics is fundamentally tilted away from the Delta? In the next section I turn to the growing literature on the political determinants of health for guidance.

The Mississippi Delta also serves as a case study of the important role that structural racism plays in shaping the underlying conditions affecting health. Understanding of this concept is still in its infancy (Hicken et al. 2018) but refers to the "totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice" (Bailey et al. 2017: 1454). My contribution to this literature is to examine the historical currents within Mississippi that drive contemporary political dynamics and weaken democratic responsiveness and political representation for residents of the Delta. The framework of structural racism is particularly powerful because it moves us beyond the question of whether individual legislators are personally racist to an examination of how political structures and processes systematically disadvantage certain groups and privilege others.

The Political Determinants of Health

Public health is an inherently political field given its orientation to improving the conditions in which people live and the overall health of populations. Changing public policy and productively engaging stakeholders require navigating a maze of institutions and values. Mainstream public health acknowledges the importance of politics, as evidenced by the World Health Organization's conceptual framework for action (Solar and Irwin 2010). Health is described as a product of social determinants, not just behaviors and biological factors. People are not in a position to make healthy choices if they lack financial resources, education, sanitary and dignified housing, safe neighborhoods, and a built environment conducive to physical activity. The World Health Organization framework places all of these determinants within a broader context, acknowledging that these determinants are to a large degree a function of public policy, political processes, and cultural values. Power plays a central role in the understanding of social pathways and mechanisms to produce or inhibit good health (Solar and Irwin 2010; see also Phelan, Link, and Tehranifar 2010). Even so, few empirical studies in public health are devoted to understanding the role of power and political processes (Borrell et al. 2007; Mackenbach 2014).

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An informal scan of the table of contents in leading public health journals such as the *American Journal of Public Health* suggests a growing appreciation for the importance of politics and the contribution of political science to our understanding of the conditions that shape health. Even so, there is a long way to go. Bernier and Clavier (2011: 000) believe that public health is "still commonly caught in a naïve, idealistic, and narrow view of public policy." Greer et al. (2017: 109) agree, suggesting that the political nature of public health "makes the enduring paucity of political science informed analysis and strategy in mainstream public health professional culture all the more puzzling."

Public health leaders and scholars are likely to be frustrated by a lack of policy change until they develop a fuller understanding of political forces. Calls to action and calls for political will run the risk of going unheard if driven by a weak understanding of politics (Greer et al. 2017). Mackenbach (2014: 2) similarly warns that "it is better to come to this arena with realistic expectations about what politics can achieve because lack of knowledge will otherwise foster romantic illusions." Oliver (2006: 195) frames this in more positive terms, articulating what is to be gained: "Public health professionals who understand the political dimensions of health policy can conduct more realistic research and evaluation, better anticipate opportunities as well as constraints on governmental action, and design more effective policies and programs."

Where to start? Kickbusch (2015: h81) provides a useful definition, that "looking at health through the lens of political determinants means analyzing how different power constellations, institutions, processes, interests, and ideological positions affect health within different political systems and cultures and at different levels of governance." Most of the research examining these types of variables has been conducted by scholars in Europe doing large-sample cross-national studies. Literature reviews of this work indicate that the earliest such studies began in the 1990s (Beckfield and Krieger 2009). This is a young field.

Some of the most widely cited works were conducted by Navarro and colleagues more than 15 years ago. These studies typically compared wealthy nations comprising the Organization for Economic Co-operation and Development (OECD) to examine a relationship between political variables and population health outcomes. For example Navarro and Shi (2001) found that infant mortality rates were significantly better in OECD countries between 1945 and 1980 when led by parties committed to redistribution. Navarro et al. (2006) extended the time period over 50 years and again found a compelling link between health and political variables such as party ideology.

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Democracy is one of the most consistently studied concepts in this literature. Do countries with democratically elected leaders have better health than those led by authoritarian regimes? The answer is consistently yes: democracy seems to be good for population health (Klomp and de Haan 2009; Chuang et al. 2013). Patterson and Veenstra (2016) used a data set with 168 countries and 50 years of data to estimate that electoral democracies have life expectancy 11 years longer and 62.5% lower rates of infant mortality.

Scholars have more recently begun to grapple with the idea that not all democracies are created or experienced equally (Mackenbach and McKee 2015). Patterson (2017) examined 179 countries between 1975 and 2012 and concluded that democracies with proportional representation electoral systems have better life expectancy and infant health. He also found no statistical evidence that majoritarian democracies—such as the United States—have better health outcomes relative to autocracies in which one person has absolute power.

Others have argued for moving past this phase of large-sample cross-national comparisons to a focus on better understanding potential causal mechanisms. Mackenbach (2014) suggests the importance of balancing quantitative methods with in-depth qualitative analysis of specific cases. Kokkinen and Muntaner (2016) similarly warn that in some cases the variables chosen for cross-national comparison are too detached from their context because they are not sufficiently motivated by theory. They call for a comparative-historical case-study approach to be more fully embraced because it allows for an understanding of how variables work together rather than in isolation as in a regression.

These findings are helpful as we consider how to examine the political determinants of health in the United States. My in-depth focus on the Mississippi Delta is consistent with Kokkinen and Muntaner's (2016) call for a comparative-historical approach to studying the relationship between politics and health. In this article I examine the political dynamics in the Dlta, paying particularly close attention to the two variables regularly highlighted in this literature: the role of parties and the quality of democracy. Before doing so, it will be helpful to briefly orient the reader to the geography and culture of the Mississippi Delta.

Geographic and Cultural Context: Where Is the Delta?

The "Mississippi Delta" is a vague term that means slightly different things depending on the context. In its broadest sense it refers to the Mississippi

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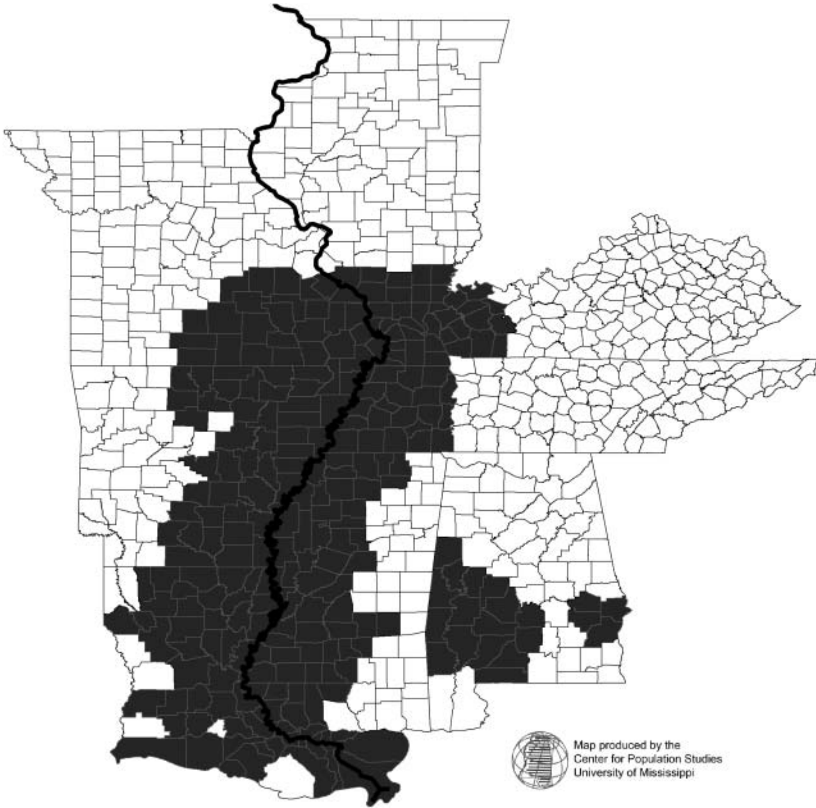

Figure 1 Counties across eight states comprising the Delta Regional Authority.

River alluvial plain stretching from southern Illinois to the mouth of the Mississippi River in Louisiana. Some organizations encompass this broad definition of the Delta. For example, the Delta Regional Authority is a federal-state partnership including counties in eight states: Illinois, Missouri, Kentucky, Tennessee, Arkansas, Louisiana, Mississippi, and Alabama (see fig. 1).

The Mississippi Delta is typically understood as the area in the northwestern part of Mississippi between the Mississippi River and the Yazoo River. David Cohn describes the Delta as beginning in the lobby of the Peabody Hotel in Memphis and stretching to Catfish Row in Vicksburg (Cobb 1992). However, these definitions are problematic because they mask major differences between places on the eastern edge of the Delta.

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They also do not match political boundaries for county lines and legislative districts and so are not easily operationable for analysis. A county that has any part between the two rivers is often included in statistics about the region, meaning that some data on the Mississippi are misleading about the depth and scope of problems in the region.

The Mississippi Delta is better understood by its cultural, economic, and sociodemographic boundaries. Tunica and DeSoto Counties epitomize the differences between what have been described as the core and periphery counties of the Mississippi Delta (Saunders 1992) (see fig. 2). DeSoto is on the border with Tennessee and is the northernmost county in what is considered the Delta's peripheral counties. It is often included in statistics about the Delta, though it is the healthiest county in the state and is 66% white and 20% rural (Robert Wood Johnson Foundation 2017). The western part of DeSoto County—the area closest in geography to the parts of the state most commonly considered to be in the Delta—is represented in the Mississippi House of Representatives by a white Republican who beat his Democrat opponent by nearly 50 percentage points in the 2015 legislative elections.

By contrast, neighboring Tunica County—which is unquestionably one of the Mississippi Delta's core counties—is represented in the Mississippi legislature by a black Democrat who won by more than 40 percentage points in 2015. Tunica ranks 60th out of the state's 82 counties in terms of health outcomes and is 75% black and 66% rural. Coahoma County, its neighbor to the south, is the least healthy county in the state (Robert Wood Johnson Foundation 2017). A county-by-county look suggests that the core Delta counties are much more like Tunica than like DeSoto and that including counties like DeSoto in statistics about the region is misleading.

Mississippi has the largest black population per capita in the United States, at 37.7% (Gates 2017). However, the black population is not evenly distributed, located disproportionately in Jackson and in the Delta. A majority of the population is black in 25 counties across Mississippi, of which 13 are in the Delta. The black population across these counties averages 69% (Jones 2017). The racial breakdown correlates closely with partisan voting patterns. Mitt Romney won the state in 2012 with 55.5% of the vote, and Donald Trump won the state in 2016 with 57.9%. Even so, Barack Obama and Hillary Clinton did very well in the Delta, typically winning more than 70% of votes in these counties (Bloch et al. 2018).

A precinct-by-precinct map of the results of the 2016 highlights the effect that racial segregation has on electoral results. Consider Clarksdale,

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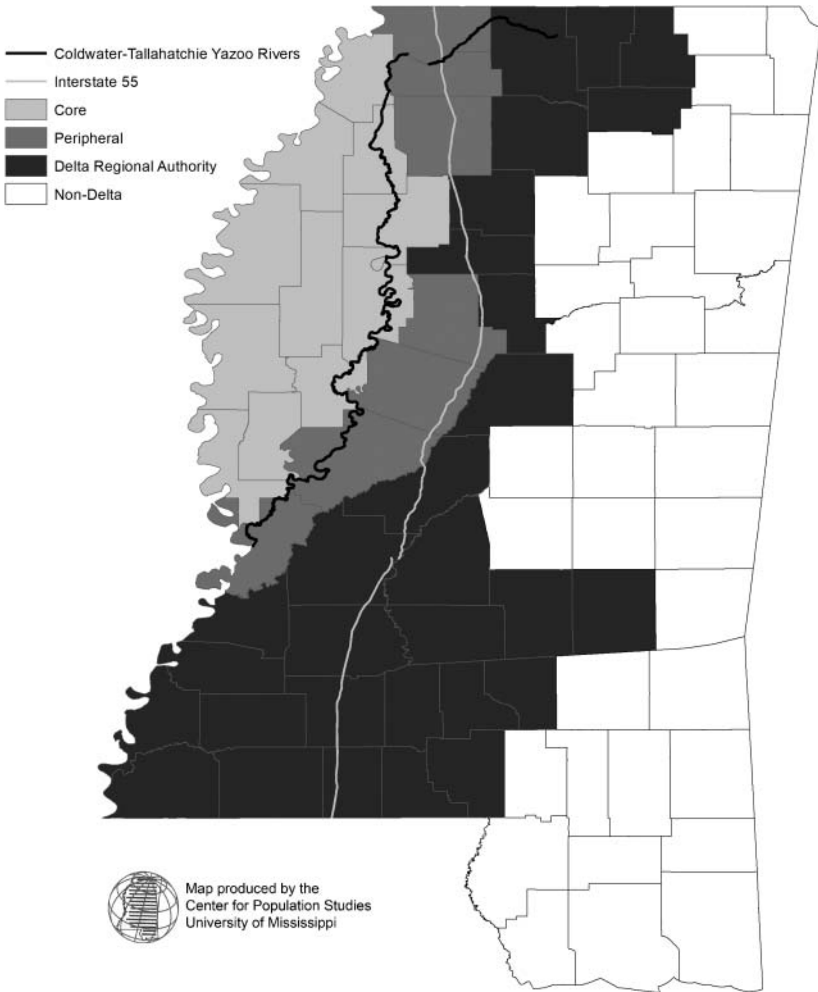

Figure 2 Counties of the Mississippi Delta.

a town of 16,000 in Coahoma County at the northern edge of the Delta. Three-fourths of residents are black, and Hillary Clinton won the county with 71.6% of the vote, compared to 27.2% for Donald Trump. But results around town vary dramatically by precinct. The vote was almost exactly split, 600–597 in the precinct northwest of town. Donald Trump won 64% of the vote in the precinct on the northern edge of the city's border. Hillary Clinton won 87% and 94% of the precincts to the east and southeast of downtown (Bloch et al. 2018). These data highlight a point I return to later,

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that how the district boundaries are drawn has important implications for whose voices are heard.

The statistics cited in the introduction hint at the staggeringly bad health conditions in the region. The Delta is to Mississippi what Mississippi is to the rest of the nation. Nearly two-fifths of residents (39%) have a body mass index greater than 30. The proportion of babies born below 2,500 grams across the heart of the Delta is greater than 18%, compared to the national average of 8.1% and the proportion of white Mississippians at 8.2%. Violent crime rates are among the highest in the nation. The area is a health professional shortage area, meaning there are not enough doctors for the population. More than a quarter of adults in the Delta lack health insurance. A similar number say they could not see a doctor because of costs. The schools are among the worst in the country, with less than two-thirds (64%) in Coahoma, Bolivar, and Washington Counties graduating high school, compared to the national average of 82%. One in three residents of the Delta say they lack adequate access to healthy food. More than a fourth of residents report a serious violation of housing safety, such as overcrowding, high housing costs, lack of a kitchen, or lack of plumbing facilities (Jones 2017).

The Ghosts of Mississippi's Past

The full history of voting, political participation, and representation in Mississippi is far too complex to discuss in depth for the purposes of this article. Entire books have been written on this subject (e.g., Key 1949; Cobb 1992; Mickey 2015; Acharya, Blackwell, and Sen 2018). In his book *Paths out of Dixie* (2015), Mickey provides an entrée to this discussion that is consistent with the focus within the literature on political determinants of health regarding the connections between democracy and health. Mickey demonstrates that until the 1970s the 11 states in the US South functioned more like authoritarian enclaves than democracies and that one cannot understand the modern South without understanding the processes and legacies of its democratization. (Mickey 2015). This process of democratization has to a large degree been driven by the politics of race.

Mississippi's racial distribution today is profoundly shaped by the profitability of cotton as farmers brought large numbers of slaves to work the fertile Delta land in the early 1800s. Acharya, Blackwell, and Sen (2016, 2018) argue that attitudes among white Southerners today are rooted in this history of slavery, providing compelling evidence that "whites who live in counties that had high concentrations of slaves in 1860 are today on average

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more conservative and express colder feelings towards African Americans than whites who live elsewhere in the South" (Acharya, Blackwell, and Sen 2016: 621). The wealthy white class in the Delta, where slave ownership was higher than in the rest of the state (Acharya, Blackwell, and Sen 2016), has wrestled with the tension that they want power to be concentrated in their part of the state but that they are a racial minority in their districts and counties.

Four key episodes of institutional reform have shaped today's political dynamics within Mississippi, mostly in ways that have reinforced structural racism and allowed the white elite class to maintain power. First, the adoption of a new state constitution in 1890 was a major turning point. The Reconstruction period brought dramatic changes in the balance of political power between the races in ways that did not favor the white wealthy class. The first post-Civil War elections in 1867 and 1869 sent 115 black legislators to Jackson, 13 in the Senate and 102 in the House (Orey 2000). US senators were at this time selected by state legislatures, meaning that this group was able to send two black men—Hiram Revels and Blanche Bruce—to Washington, DC to represent Mississippi in the US Senate in the 1870s.

The white leadership of the state's Democratic Party felt appropriately threatened by these radical changes. They responded by pushing for the adoption of a new state constitution that would change rules to their benefit. The new constitution did not need to be ratified by popular vote and could be written by a small group of delegates. Turnout for the elections to select delegates in 1890 was extremely low, giving Democrats a dominant hand in the process (Mickey 2015). All but one of the 134 delegates were white. This group of white Democrats reestablished their dominance by using a poll tax, a literacy test, and a property requirement to determine who could vote.

The new constitution dramatically weakened the powers of Mississippi's governor just in case the day came that enough black people voted to elect one of their own. Many of the functions given to governors in other states are held by free-standing boards and commissions appointed by legislative leaders or by agencies led by independently elected heads. The legacy of these decisions lingers today as the governor does not have direct control over the state's Department of Health or Department of Insurance and the legislature has greater ability than most to oversee regulations put into place by the executive branch. Lest there be any doubt about the motivation behind these changes, Solomon Calhoon, president of the constitutional convention, explained, "Let's tell the truth if it bursts the bottom of the

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universe—We came here to exclude the Negro. Nothing short will answer" (quoted in Danielson 2013: 42).

The new constitution had its intended effect. Voter registration among black Mississippians fell from 70% in 1867 to 6% in 1892 (Cobb 1992). Black representation in the legislature ended immediately, such that no black person served in the state legislature between 1896 and the passage of the Voting Rights Act of 1965 (Orey 2000).

The Delta—or at least the Delta's wealthy white class—maintained a powerful presence in state politics during this period. There were only three times between 1916 and 1940 in which the Speaker of the House was not from this part of the state. These Speakers gave leadership positions in key committees to legislators from majority-black districts in order to further consolidate power in favor of white Delta farmers (Cobb 1992). Mickey (2015) lists the structural advantages that the Democratic party had, such as favorable districting, seniority, and control of campaign finances.

Second, landmark Supreme Court decisions and acts of Congress during the mid-20th century began to erode the grip on power enjoyed by white Democrats. *Smith v. Allwright* in 1944 found that state parties could no longer hold white-only parties in which candidates were chosen by a group of electors explicitly defined by their race. Dramatic and persistent political mobilization by activists such as Fannie Lou Hamer, Amzie Moore, and Aaron Henry—as well as the college-age Northerners during the Freedom Summer—contributed to such important gains as the Civil Rights Act of 1964 and the 1965 Voting Rights Act. On paper these changes ended Jim Crow across the South and eliminated suffrage restrictions such as the poll tax and literacy test. Epidemiologists recently quantified the effects of racial segregation at this time, saying that African Americans living under Jim Crow laws across the South were 20% more likely to die prematurely than those living in areas without Jim Crow restrictions (Krieger et al. 2014).

These laws of the mid-1960s gave the US Department of Justice significant oversight of state elections. That Mississippi resisted change most fervently meant that federal officials had a stronger presence here than anywhere else in the South. Between 1965 and 1980, 51% of Mississippi's counties were subject to federal examiners (Mickey 2015).

All of these changes had a dramatic effect on voting patterns. Less than 1% of voting-age black Mississippians was registered to vote in 1940, and just 21% of white voters across the state could elect a majority of the legislature (Mickey 2015). By 1960 the percentage of voting-age black

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Mississippians registered had increased but was still only 5%. Ten years later this increased to 68%, the highest in the Deep South (Mickey 2015).

Third, Mickey (2015) describes 1972 as the transition year in which democratization was fully consolidated in the US South. However, despite having made major progress, recent changes did not necessarily ensure democratic responsiveness for black Mississippians. The absolute number of new white registrants was dramatically higher than that of blacks. This dramatic increase may have been in response to fears about what increases in black voting would mean but was also likely a product of the removal of suffrage restrictions. Although not as strictly enforced as in the black population, some poor white people were also limited in their ability to vote because of the poll tax, property requirement, and literacy test (Mickey 2015).

Many states responded to the broad national changes by switching their state legislative elections to multimember districts. Rather than elect a single candidate, voters would select who would fill the entire number of seats. The implication was that, as a majority across the state, white people could select who served in the legislature, denying black-majority communities the opportunity to select their representative. For example, a district was created in Hinds County, which was 40% black, such that all 10 of the county's house seats would be elected at-large. As a result, 60% of white voters in this area selected the 10 elected officials (Parker 1990).

The state legislature's decision in 1979 to respond to a Supreme Court ruling by eliminating multimember districts led to an increase in the number of black legislators from 4 to 17. Even so, this was still only 12% of the house membership and 4% of the senate, far below the statewide black population of 36% (Menifeld, Shaffer, and Jones 2000).

Fourth, redistricting following the 1990 Census had the most profound effect on the racial composition of the legislature in a century. By 1992, there were 31 black legislators in the House and 10 in the Senate. Of similar importance, a handful of these black legislators were selected to serve in leadership positions, including Robert Clark as the Speaker Pro Tempore (Menifeld, Shaffer, and Jones 2000).

Even so, analysis of this period by Orey (2000) suggests that the increased numbers of black legislators and even leadership positions did not necessarily translate to greater influence over policy making. Districts were drawn such that large numbers of black people were consolidated together, weakening black representation in the legislature. As a progressive white Democrat said after the 1992 elections: "You end up with radicalized White districts and radicalized Black districts in which the White

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representatives don't have to take into consideration the needs and wants of Black people in the state and Black people don't have to take into consideration the needs and wants of Whites because they represent such a small number that they don't have to cater to their interests to get elected" (quoted in Orey 2000: 809). The head of the Mississippi legislature's Black Caucus had a very similar response to the redistricting: "There is an effort to send a message to us, and to Black Mississippians, that no matter what your numbers are in the Legislature, we're going to still control things" (quoted in Orey 2000: 809).

Orey (2000) sought to evaluate this claim by comparing the percentage of bills introduced by black legislators to a control group of white legislators. Black legislators succeeded at passing 12% of the 166 bills they introduced in 1987 and 5% of the 285 bills they introduced in 1988. A comparison group of white legislators was able to pass 28.5% and 21.1% of their bills in these years. Orey concluded from these numbers and from key informant interviews that black legislators were systematically excluded from the power structures of state government in ways that limited their ability to influence policy.

Mississippi Today

What are the power dynamics within the Mississippi legislature today? Are the Delta's legislators able to advance legislation responding to the needs and desires of their constituents? I examined these questions by developing an original data set tracking the path of every bill introduced during the 2017 session of the Mississippi legislature and using the same approach as Orey (2000). Information about legislators and bills was obtained from the official website of the Mississippi legislature. This methodology has major limitations in that it does not allow for making causal claims or saying anything about the degree of influence legislators from the Delta have in behind the scenes negotiations about bills authored by other people. We also do not know the extent to which expectations about success affects the number of bills legislators introduce in the first place. But these data do help paint a picture of institutional power today. This analysis comes at an interesting turning point in the state's history, as the state had just completed the transition from being led by southern Democrats, with Democrats losing control of the House in 2015 for the first time since Reconstruction. One implication of this shift is that the state Democratic Party is now more closely aligned in terms of ideology and policy preferences with the national Democratic Party. Party is therefore a reasonable proxy for the

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attitudes of state legislators toward public health, given a recent study showing that Democrats in the US Senate were significantly more likely to vote for public health policies than were their Republican counterparts (Purtle et al. 2016).

The 2017 State House

A total of 2,832 bills were introduced in the Mississippi legislature in 2017, of which approximately two-thirds (1,813) originated in the House. Republicans enjoyed a 74–48 majority in the House (61%) and authored a roughly proportional 58% of the bills introduced there. Descriptive statistics on the 2017 bills originating in the House are presented in table 1. Democrats were considerably less successful than Republicans at passing legislation: Democrats were able to enact only 0.31 bills per House representative, whereas each House Republican enacted an average of 1.99 bills. Interestingly, Democrats from the Delta had a higher success rate than Democrats from outside the Delta, but they were more selective in the number of bills authored and still passed far fewer than Republicans.

The degree to which Democrats from the Delta were dwarfed by Republicans in terms of their ability to advance their policy agenda is more fully appreciated by considering the scope of the eight bills authored by Delta Democrats that were enacted. Three of these bills authorized a particular county to spend between $2,500 and $10,000 of its own money to make a contribution to a local organization. One bill allows Delta State University in Cleveland, Mississippi, to continue leasing land to a golf course. The most consequential of these bills in terms of policy allows Bolivar County to continue its tax on hotels until 2021 and to allow Grenada County to house prisoners from other parts of the state. These bills are hardly far reaching and do little to address the stark needs of the least healthy place in the country.

Not all Republicans passed legislation that was more than symbolic, but a much higher percentage of them were successful compared to Democrats. A little less than half of Republicans (36) saw at least one of their authored bills make a meaningful change to state law, touching on such issues as cybersecurity, Medicaid fraud, fantasy sports betting, prisons, taxes, and the death penalty. At least 20 House Republicans had multiple such bills enacted.

Legislators may have power to shape legislation in other ways besides authoring bills, including cosponsoring legislation introduced by others. However, Republicans again seem to enjoy much greater levels of success

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Table 1 Legislative summary: 2017 Mississippi House

Total number of bills originating in the House	1813
Number of bills authored per legislator	14.86
Republicans	14.15
All Democrats	15.96
Delta Democrats	11.64
Non-Delta Democrats	17.24
Number of enacted bills originating in the House	162
Republicans	147
All Democrats	15
Delta Democrats	8
Non-Delta Democrats	7
Number of enacted bills authored per legislator	1.33
Republicans	1.99
All Democrats	0.31
Delta Democrats	0.73
Non-Delta Democrats	0.19
Average success rate per legislator	8.90%
Republicans	14.00%
All Democrats	2.00%
Delta Democrats	6.30%
Non-Delta Democrats	1.10%
Average success rate of cosponsored bills	26.90%
Republicans	33.10%
All Democrats	19.90%
Delta Democrats	17.50%
Non-Delta Democrats	20.30%
Number of bills enacted per committee controlled by	
Republicans	3.98
Democrats	1.00
Success rate of bills introduced in committees chaired by	
Republicans	7.78%
Democrats	6.90%

than Democrats (33.1% vs. 19.9%), with Democrats from the Delta fairing slightly worse than their non-Delta counterparts (17.5% vs. 20.3%).

Influence on legislative committees is another important way to examine how successful Democrats from the Delta were during the 2017 session. Orey (2000) found that black legislators in 1987 were systematically excluded from leadership on the most powerful committees, such as appropriations, agriculture, banking, education, judiciary, and ways and means. The same seems to be true today.

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The legislature's website lists 46 committees in the House in 2017, of which five had no activity that year. The Energy Committee was chaired by a Democrat, as was the Youth and Family Affairs Committee. Both chairs were black but neither was from the Delta. The overall success rate of all bills introduced in committees chaired by Republicans and Democrats were pretty similar, suggesting that Republican chairs did not have a stronger ability to exert their will on their committee. However, these percentages obscure the dramatic difference in raw numbers. House leadership sent far more bills to the 41 active committees chaired by Republicans than to the two chaired by Democrats. Even though the success rate between committees was similar, Republican-controlled committees enacted nearly four times as many bills as committees controlled by Democrats.

Again, these comparisons were between committees controlled by Republicans and those controlled by Democrats. Legislators from the Delta did not chair a single House committee and so had no ability to influence policy making through committee leadership. This is not to say that no one from the Delta was on important committees. Two legislators from the Delta served on appropriations, arguably the most influential committee in the House. However, they had very little ability to sway the committee given that they were just 2 of 10 Democrats and just 6% of the relatively large committee consisting of the 33 legislators.

The 2017 State Senate

The picture in the Senate is a little fuzzier but leads to a similar conclusion: that today's legislators from the Dlta have very little influence on legislative decision making in Mississippi. Democrats occupy 20 of the 52 seats, of which 13 legislators are black and 4 are from the Delta. Part of the challenge of evaluating legislative influence is that parts of the Delta are sliced into districts that either are not representative of the Delta's demographics or mean that the person elected to serve people in the Delta arguably lives outside the region.

The most striking example is Senate District 22, represented by Eugene "Buck" Clark, a white Republican from Hollandale. The oddly shaped district shares a border with 10 other senate districts and stretches more than 100 miles through parts of six counties. The district includes rural parts of Washington and Bolivar Counties but not the heavily black populations of Greenville and Cleveland or the heavily black population of Jackson, which is near the district's southern border. Senator Clark's district is 55% black and 41% white and has a median income of $37,400. By contrast, the

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Delta counties that are partly in his district are on average 67% black and 30% white and have a median income of $26,650. The legality of the district was challenged in July 2018 in a lawsuit filed by Joseph Thomas, a former state senator who between 2004 and 2008 served in a district that at the time was adjacent to Senator Clark's (Pettus 2018).

Senator Clark serves as chair of the Senate Appropriations Committee, giving him a prominent role in shaping policy. As a result, Senator Clark is the primary sponsor of by far the largest number of enacted bills in the Senate. The next highest after his 55 enacted bills is 6, and the average for every other senator is 1.5. His success rate of 86% is second highest only to Senator Gary Jackson, who successfully passed the only bill he introduced. Senator Clark's success rate is perhaps artificially high given that the legislature has to pass appropriations bills each year to fund the government. But these numbers do reflect the enormous power he has in shaping how money is spent in Mississippi.

Senator Clark's prominent role does not necessarily translate to greater resources for the Delta. Instead, his role brings to mind the days of the early 20th century when white Democrats from the Delta held key leadership positions at the expense of representing the majority's perspective in the region.

As depicted in table 2, the trend in the Senate is similar to that in the House, with Delta Democrats having a higher success rate of enactment (7.3%) than Democrats from elsewhere in the state (2.1%) but having dramatically less success than Republicans (13.2%). Senator Willie Simmons stands out, having authored half of the eight enacted bills written by Delta Democrats. Senator Simmons is an institution in his district centered on Cleveland, having served in the Senate since 1993. He is well known for his restaurant, the Senator's Place, which was featured on Anthony Bourdain's *Parts Unknown* in 2014. Three of his four bills are very similar to the types of bills passed by House Democrats from the Delta, including the extension of the hotel tax in Indianola County and the authorization for Bolivar County to contribute $10,000 to a local cancer foundation. However, Senator Simmons was also the primary sponsor of a high profile bill with potentially important public health consequences. S.B. 2724 amends Mississippi law, that previously had only required drivers to wear a seatbelt, by saying that all passengers must do so as well (Pettus 2017).

It is not clear whether there is a trend in the data on co-sponsoring in the Senate. Republicans had higher success rates at 34.1% compared to 26% for Democrats in the Delta and 24.1% for Democrats overall. But the smaller number of senators means that a higher percentage of them are on the Appropriations Committee and are therefore cosponsors on a large

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Table 2 Legislative summary: 2017 Mississippi Senate

Total number of bills originating in the Senate	1019
Number of bills authored per legislator	19.60
Republicans	19.52
All Democrats	19.60
Delta Democrats	21.80
Non-Delta Democrats	17.69
Number of enacted bills originating in the Senate	134
Republicans	120
All Democrats	14
Delta Democrats	8
Non-Delta Democrats	6
Number of enacted bills authored per legislator	2.58
Republicans	3.70
All Democrats	0.70
Delta Democrats	1.60
Non-Delta Democrats	0.38
Average success rate per legislator	13.15%
Republicans	18.94%
All Democrats	3.57%
Delta Democrats	7.34%
Non-Delta Democrats	2.12%
Success rate of cosponsored bills	30.29%
Republicans	35.82%
All Democrats	24.12%
Delta Democrats	25.96%
Non-Delta Democrats	23.41%
Number of bills enacted per committee controlled by	4.65
Republicans	5.92
Democrats	0.50
Success rate of bills introduced in committees chaired by	
Republicans	12.24%
Democrats	4.94%

number of successful bills. However, legislators from the Delta do not have a particularly large contingent on the Appropriations Committee, where the most consequential decisions are made. Other than Senator Clark, only 2 of the 26 senators on the Appropriations Committee are from the Delta: Willie Simmons and Robert Jackson, a black Democrat from Marks.

One major difference from the House is that Democrats control a higher proportion of legislative committees in the Senate. Democrats have 40% of the overall seats and control a roughly proportional 30% of the committees.

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Delta Democrats control 3 of the chamber's 34 current committees, but they are not particularly active committees. The Drug Policy Committee only considered two bills in 2017, of which one passed.[1] The Highways and Transportation Committee, chaired by Willie Simmons, enacted 2 of the 25 bills it considered. The Interstate and Federal Cooperation Committee, chaired by Robert Jackson of Marks, did not consider any bills. By contrast, committees chaired by Republicans were assigned an average of 48.3 bills and successfully passed 5.9 per committee.

Taken together, these descriptive data paint a picture of Republicans fully in charge of policy making in the state of Mississippi.

Discussion

This article does not paint an optimistic picture. A deep dive into the past and present of Mississippi politics suggests the importance of the deep connections between democratic responsiveness, power, and health. There are reasons to be skeptical that increased political participation by black residents of the Dlta, such as turning out to vote in greater numbers, will lead to the adoption of policies aimed at improving the social determinants of health in the dDelta. Systemic and institutional barriers to power suggest that such policies cannot happen without the support of white residents, particularly those living in other parts of the state. More broadly, health equity is not likely to be achieved unless leaders outside the area with the greatest need buy in and step up.

These conclusions are consistent with the political science literature on representation and provide a microlevel view of the processes at play. For example, Gilens (2005) found that, although there is a relationship between what Americans say they want and what government does, public opinion among the wealthy seems to matter the most. As Gilens and Page (2016) wrote in the *Washington Post*, "Americans who are less well-off have essentially no influence over what their government does." Schlozman, Brady, and Verba (2012, 2018; Verba, Schlozman, and Brady 1995) have written three comprehensive books about who participates and whose voice is heard in American politics. This line of research tends to focus on the degree to which political engagement is shaped by a population's wealth, access to information, amount of disposable time, and level of civic skills, as well as the strategic choices made by parties to appeal to wealthy voters (Bartels 2016; Rigby and Wright 2013). However, the

1. S.B. 2194, authored by Delta Democrat David Jordan, adds fentanyl to the state's Uniform Controlled Substance Law.

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situation in the Mississippi Delta puts a slightly different spin on the problem of limited political representation for people lacking resources. In this case, the preferred candidates—at least for the state legislature—are already winning. The institutional barriers to policy are unlikely to be overcome by greater political engagement by residents of the Delta.

Michener (2017: 000) diagnosed places like the Delta as suffering from "policy concentration," which she defines as "a form of concentrated advantage that happens when particular geographic locales have disproportionate numbers of residents affected by a given policy." She writes that "the geographic concentration of inequity is a key mechanism of inequity" (000). Her focus is on the actual experience that people have with government programs such as Medicaid, observing that the need for help in places with disproportionately large numbers of beneficiaries far exceeds the capacity of local government offices. Political participation, such as belonging to a party and aggregate rates of voting, decreases as people become cynical about government's ability to address their needs.

Michener (2017: 000) concluded that "advancing health equity will therefore require crafting, passing, and implementing policies that offset the penalties of concentrated disadvantage." She calls on the communities with most at stake to mobilize and demand such policies. My analysis in Mississippi suggests another disadvantage of policy concentration: that democratic responsiveness for the concentrated population is limited as long as the rest of the state maintains control of key institutions. Unfortunately, this means that mobilization by the populations experiencing policy concentration will likely not yield much change.

I considered including an analysis of voter turnout by race, party, and/or district. However, the above insights about institutional barriers suggest that they probably would not have revealed anything different. The story of Delta residents lacking a strong political voice in state politics would look very similar even if voter turnout among black residents of the Delta was dramatically higher—the same candidates would likely go to Jackson, where they would not have much influence. This is important context for understanding the meaning and implications of studies that use such measures of participation (see contributions in this special issue by Haselswerdt and Michener and by Ojeda and Slaughter).

My examination of the Delta has largely focused on political representation with respect to the state legislature. The nature of the problem is a little different in terms of voice in national and local politics, but understanding the state-level dynamics is a critical element of understanding representation at these levels. City and county leaders are to a large degree constrained in their policy options by the state's fiscal and legal

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environment. Similarly, the marble cake of intergovernmental relations regularly gives state leaders an important role in the implementation and operation of federal law.

In some cases, federalism presents all-or-nothing choices for states such that it is not possible for leaders to be democratically responsive to a region within the state whose preferences differ from the rest of the state. Blue cities in red states—such as Houston and Salt Lake City—deal with this on a regular basis (Meyerson 2016). Medicaid expansion in Mississippi is another good example of this dynamic. The Delta consistently elects people who support Medicaid expansion, but they are stymied by leaders from other parts of Mississippi responding to a statewide majority opinion opposing expansion. The program's design does not allow for coverage expansions within parts of a state, meaning the Delta will not benefit from this key feature of the Affordable Care Act unless state leaders ignore popular opinion or attitudes change elsewhere.

Three southern states have already expanded Medicaid—Arkansas, Kentucky, and Louisiana—but it is hard to imagine Mississippi joining that list soon. Support for Medicaid is so weak in Mississippi that the existence of the program to any degree has to be reauthorized on an annual basis. This has always happened but is regularly contentious. It is difficult to disentangle its effect, though race is clearly a factor. Lanford and Quadagno (2015) show that states with higher levels of racial resentment are less likely to adopt the Medicaid expansion. Similarly, Grogan and Park (2017) demonstrate that states with large black populations were significantly less likely to adopt the Medicaid expansion, especially when white support for the expansion was low. They write that their conclusions "raise serious questions about minority representation and whether the denial of access to public health insurance in states that rejected the Medicaid expansion is democratically just. . . . This study raises questions about to whom states are democratically accountable" (000).

All three southern states to expand Medicaid were led by a Democratic governor at the time. John Bel Edwards's election as governor of Louisiana gave hope to supporters of the Affordable Care Act that a pro-Medicaid Democrat could win in the South. However, his victory should not necessarily be understood as an indication that white Southerners now support Medicaid expansion. Scandal over the sexual impropriety in his opponent's past was likely a bigger factor than Medicaid in shaping the outcome of that race.

Could a Democrat be elected governor of Mississippi? Doug Jones's senate victory in neighboring Alabama does indicate that a Democrat

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can win statewide office in the Deep South. Black residents of the Delta wondering whether their vote matters should look to this race as hopeful evidence. State legislative districts are drawn such that it is unlikely that greater turnout will sway the outcome of enough races to influence which party controls the Mississippi House or Senate. But there is no way to gerrymander a governor's race.

A Democrat would have a shot if black voters turned out in the off-cycle governor's race at the same levels as they do in presidential elections and white voters do not. Senate candidate Mike Espy, a black Democrat who served as Bill Clinton's secretary of agriculture and is originally from Yazoo City, the "Gateway to the Delta," is testing this theory. Espy estimates that he needs only 25% of the white vote. However, this would be a big jump, as Democrats in statewide races typically receive around 10% of the white vote in Mississippi (Bohan 2018). Anything he does to make his candidacy more palatable to white voters risks alienating and diminishing enthusiasm among black voters. His campaign will be studied by anyone considering running for governor in the next race of 2019 or beyond. However, there is reason to be skeptical that even electing a Democratic governor would substantially change the power dynamics in Mississippi. As described earlier, the Mississippi Constitution of 1890 dramatically weakened the powers of Mississippi's governor just in case enough black people mobilized to elect someone undesirable to the wealthy white class.

One of the key lessons from this in-depth examination of politics in the Mississippi Delta—and core arguments of this article—is the importance of developing a richer understanding of the relationship between politics and health. A growing number of scholars have called for public health researchers and leaders to more fully appreciate the political determinants of health (Marmot 2005; Oliver 2006; de Leeuw, Clavier, and Breton 2014; Mackenbach and McKee 2015; Greer et al. 2017). Gagnon et al. (2017: 495) argue that, despite progress, "close linkages between researchers in public health and in political science are a long time coming." Much of the burden to make this happen rests with the public and private organizations that support and promote public health research and the researchers who carry it out. Both must do a better job of funding, developing, and citing research that examines political dynamics. But political science also has a responsibility. Carpenter (2012) suggests that the study of health politics is in its infancy and that political scientists need to more fully appreciate that health politics is different from the politics of other policy domains.

This look at the history and present-day dynamics in Mississippi makes it clear that simply calling for action and increased political will reflects a

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fundamental lack of understanding of the obstacles to achieving health equity. That the Mississippi Delta has such dramatically bad health outcomes is clearly not simply a result of genetics and unhealthy behaviors. Policy decisions with important health implications might look different if the political dynamics in Mississippi were to a greater degree democratically responsive to all residents in the Delta. This includes the decision to reject the Affordable Care Act's Medicaid expansion despite the state's dramatic gaps in insurance coverage. This includes spending $33,335 less per student in the education budget relative to the national average (Skinner 2018). It also includes severe gaps in publicly funded infrastructure, exemplified by a recent report that majority-black counties with Democratic-leaning populations—such as the Mississippi Delta—are disproportionately affected by bridge closures (Ganucheau and Rozier 2018), which exacerbate preexisting gaps in transportation in the region. Similarly, alternative solutions to the state's infrastructure needs might have been sought other than the creation of a lottery in August 2018, which critics contend is likely to be a regressive tax on the poor who most need the help (Ganucheau and Harrison 2018).

An in-depth analysis of political dynamics in Mississippi makes it clear that policy decisions such as these affecting the social determinants of health cannot be understood without grappling with the role of institutions, structural racism, governance processes, cultural dynamics, demographics, and history.

▪ ▪ ▪

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Acknowledgment

No funding was received to support this research, and no funds were used in carrying out this work.

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