

MARCH 17, 2021 | NUMBER 255

The Federal Effort to Desegregate Southern Hospitals and the Black–White Infant Mortality Gap

BY D. MARK ANDERSON, MONTANA STATE UNIVERSITY; KERWIN KOFI CHARLES, YALE UNIVERSITY; AND DANIEL I. REES, UNIVERSITY OF COLORADO DENVER

In the Jim Crow era, Southern hospitals were racially segregated. Hospitals that focused on providing care to black patients (i.e., “black hospitals”) were, with a few exceptions, understaffed and lacked the latest medical technology. White-run hospitals could be biracial, but black patients were physically separated from their white counterparts and did not receive equal care. Eradicating this entrenched system of racial discrimination and exclusion was a key objective of the American civil rights movement.

Under political and legal pressure, a handful of hospitals in the South desegregated between 1962 and 1965. Most, however, remained racially segregated until 1966, when the Johnson administration threatened to withhold Medicare funding from hospitals not in compliance with the Civil Rights Act of 1964. The newly created Office of Equal Health Opportunity (OEHO) was tasked with determining whether hospitals were in compliance. Beginning in April of 1966, OEHO investigators, working closely with civil rights activists, visited hospitals across the country with the goal of identifying and correcting discriminatory practices. Six months later, more than 7,000 hospitals had been certified by the OEHO as eligible to receive Medicare funds; 214 Southern hospitals opted to remain racially segregated, forgoing all federal funding.

The federal campaign to desegregate Southern hospitals has been described as a “powerful force for equal treatment” and “among the most important civil rights achievements in U.S. history,” yet, with one prominent exception, its effects on black health are woefully understudied. Using data from Mississippi, economists Douglas Almond, Kenneth Chay, and Michael Greenstone show that the black postneonatal mortality rate fell faster in counties that were served by a Medicare-eligible hospital than in counties that were not. They conclude that hospital desegregation saved thousands of black lives and contributed substantially to the narrowing of the national black-white postneonatal mortality gap, but they do not account for the strong preexisting downward trend in the black postneonatal mortality rate.

We use data from the National Vital Statistics System to examine the effects of the hospital desegregation campaign on black infant mortality and the decision of where to give birth (i.e., at home or in the hospital). By focusing on five states in which support for segregationist policies and practices was especially staunch (Alabama, Georgia, Louisiana, Mississippi, and South Carolina), we are able to leverage sufficient cross-county variation in Medicare certification dates to distinguish the effects of hospital desegregation from secular trends. Our results suggest that having

access to a Medicare-eligible hospital had little, if any, effect on infant mortality. Specifically, we find that having access to a certified hospital is associated with 1.37 additional black infant deaths per 1,000 births. Although this estimate is not statistically significant, it is sufficiently precise to reject the hypothesis that the hospital desegregation campaign contributed meaningfully to the narrowing of the black-white infant mortality gap. Likewise, we find that having access to a Medicare-eligible hospital had no appreciable effect on the black postneonatal mortality rate, nor did it affect black infant deaths due to preventable causes, such as pneumonia, influenza, and diarrhea. Again, these estimates are measured with precision, allowing us to reject the hypothesis that the hospital desegregation campaign drove the narrowing of the black-white postneonatal mortality gap.

We also explore whether the hospital desegregation campaign accelerated the trend toward in-hospital births among Southern black mothers. We find that having access to a Medicare-eligible hospital is associated with an increase in the rate at which black mothers chose to give birth in-hospital and a similarly sized decrease in out-of-hospital black births attended by a midwife. These estimated effects are, however, not nearly large enough to explain the trend toward in-hospital births.

The litmus test for Medicare eligibility was random assignment. OEHO investigators required that patients be assigned to physicians and hospital beds without regard to race,

color, or national origin. The investigators could not, and were not asked to, address fundamental structural barriers that prevented minority patients from accessing high-quality health care. Nor could they expunge difficult-to-observe racial attitudes and modes of communication that, to this day, shape the delivery of health care in the United States. In 1972, the Government Accountability Office released an assessment of hospital compliance with the Civil Rights Act of 1964. The report concluded that the hospital desegregation campaign had virtually eliminated overt racial discrimination, while more-subtle forms of racial discrimination persisted. Our results suggest that correcting overtly discriminatory practices on the part of Southern hospitals was simply not enough to ensure that black infants experienced the same health outcomes as their white counterparts. More generally, our results are consistent with an argument from the anti-discrimination literature that punitive actions against employers are of limited effectiveness because they do not address underlying biases and prejudices.

NOTE:

This research brief is based on D. Mark Anderson, Kerwin Kofi Charles, and Daniel I. Rees, “The Federal Effort to Desegregate Southern Hospitals and the Black-White Infant Mortality Gap,” NBER Working Paper no. 27970, October 2020, <http://doi.org/10.3386/w27970>.