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A Review of Events Affecting Negro Life

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VITAL STATISTICS

The interpretation of vital statistics is well stated in this population census statement:

> The developments of statistics are causing history to be rewritten. Till recently, the historian studied nations in the aggregate and gave us only the story of princes, dynasties, sieges and battles. Of the people themselves—the great social body, with life, growth, forces, elements, and laws of its own—he told us nothing. Now statistical inquiry leads him into hovels, homes, workshops, mines, fields, prisons, hospitals, and other places where human nature displays its weakness and its strength. In these explorations he discovers the seeds of national growth and decay, and thus becomes the prophet of his generation.

The public health scientist observes in matters pertaining to the control of communicable disease that "no health officer can control disease in his community unless he knows when, where, and under what conditions cases are occurring."

The following tables and comments provide comparable data by race, not only for factual information but also for incentive to analysis of the figures and projection of their meanings into measures and methods for correction and protection.

Birth and Death Rate Trends

The crude birth rate of the Negro and other colored races (the number of births per 1,000 of the population) in the United States, like that for the total population, continues the trend upward since the year 1930. Table 1 shows figures for the white and nonwhite races. In 1920, the birth rate for Negroes and other colored was 27.0; in 1930, 21.6; in 1943, 24.1; in 1949 (latest figures available) 30.3. The comparable white rates were 23.5, 18.6, 21.2, and 23.2.

Crude death rates by race per 1,000 of the population, also are shown in Table 1.

TABLE 1

RATES OF BIRTH AND DEATH AND MATERNAL AND INFANT DEATHS AND STILLBIRTH RATIOS, BY RACE [1]

Subject	1949	1943	1930	1920
Births				
Total	24.0	21.5	18.9	23.7
Negro & Other	30.3	24.1	21.6	27.0
White	23.2	21.2	18.6	23.5
Deaths				
Total	9.7	10.9	11.3	13.0
Negro & Other	11.1	12.8	16.3	17.7
White	9.5	10.7	10.8	12.6
Maternal deaths				
Total	0.9	2.5	6.7	8.0
Negro	2.4	5.1	11.7	12.8
Other	1.8	4.5	—	—
White	0.7	2.1	6.1	7.6
Infant deaths				
Total	31.3	40.4	64.6	85.8
Negro	46.8	61.5	99.5	135.6
Other	58.1	84.6	108.4	89.6
White	28.9	37.5	60.1	82.1
Stillbirths				
Total	22.9	26.7	39.2	—
Negro	—	47.3	82.5	—
Other	—	22.8	24.6	—
White	—	24.2	34.0	—

[1] Rates are for death registration states. Birth and death rates per 1,000 estimated population; maternal death and infant death rates, and stillbirth ratios per 1,000 live births. Birth rates are based on total population including armed forces overseas. Death rates for 1943 are based on total population excluding armed forces overseas.

TABLE 1A

CRUDE AND AGE-ADJUSTED MORTALITY FROM ALL CAUSES [1]

Year	Death Rate Per 1,000			
	Crude		Adjusted	
	Nonwhite	White	Nonwhite	White
1919–1921	17.0	12.0	19.8	13.1
1929–1931	16.2	10.9	20.0	11.8
1939–1941	13.5	10.3	15.9	10.0
1948	11.3	9.7	12.8	8.6

Source: National Office of Vital Statistics, U.S. Public Health Service.

[1] Rates are for death registration states.

The decrease in all categories in significant evidence of the effectiveness of health education and health and welfare services. The general death rate for the Negro and other colored shows a definite trend from 17.7 in 1920 to 11.1 in 1949. The white death rate decreased from 12.6 in 1920 to 9.5 in 1949.

Maternal and infant deaths show a remarkable decline in rates for all races.

TABLE 2

RATES OF NEGRO AND WHITE MORTALITY FROM ALL CAUSES IN SEPARATE STATES, 1948

State	Population, 1950[1]		Death Rate per 1000, 1948[2]	
	White	Nonwhite	White	Nonwhite
United States	135,215,000	15,482,000	9.4	11.2
New England				
Maine	910,847	2,927	10.9	10.2
New Hampshire	532,275	967	11.6	5.2
Vermont	377,188	559	10.9	5.4
Massachusetts	4,625,000	64,000	11.2	15.1
Rhode Island	777,015	14,881	10.3	12.3
Connecticut	1,952,327	54,953	9.7	9.9
Middle Atlantic				
New York	13,902,000	928,000	10.7	10.4
New Jersey	4,557,000	278,000	9.8	12.9
Pennsylvania	9,844,000	654,000	10.3	11.3
East North Central				
Ohio	7,476,000	470,000	10.0	12.5
Indiana	3,758,439	175,785	9.9	12.8
Illinois	8,085,000	628,000	10.4	11.8
Michigan	5,920,000	452,000	8.9	8.5
Wisconsin	3,392,691	41,884	9.5	9.3
West North Central				
Minnesota	2,953,678	28,805	9.2	12.4
Iowa	2,599,566	21,507	9.9	12.4
Missouri	3,640,000	315,000	10.6	13.7
North Dakota	608,448	11,188	8.3	10.6
South Dakota	628,504	24,236	8.8	10.7
Nebraska	1,301,344	24,166	9.5	11.7
Kansas	1,828,961	76,338	9.6	12.1
South Atlantic				
Delaware	273,878	44,207	10.2	14.0
Maryland	1,954,987	388,014	9.1	12.1
District of Columbia	518,147	284,031	10.1	10.4
Virginia	2,581,642	737,038	7.8	12.1
West Virginia	1,890,284	115,268	8.5	12.6
North Carolina	2,983,110	1,078,819	6.7	9.5
South Carolina	1,293,403	823,624	7.1	10.7
Georgia	2,380,573	1,064,005	7.3	11.5
Florida	2,166,047	605,258	8.3	11.4
East South Central				
Kentucky	2,741,930	202,876	9.0	16.8
Tennessee	2,760,250	531,468	8.0	12.4
Alabama	2,079,500	982,243	7.5	11.3
Mississippi	1,188,429	990,485	7.9	11.0
West South Central				
Arkansas	1,481,508	428,003	7.3	10.3
Louisiana	1,796,548	886,968	7.6	11.3
Oklahoma	2,032,555	200,796	8.2	11.9
Texas	6,825,000	886,000	7.8	12.2
Mountain				
Montana	572,038	18,986	9.8	16.0
Idaho	581,395	7,242	8.3	12.6
Wyoming	284,009	6,520	8.1	14.1
Colorado	1,296,653	28,436	9.5	10.1
New Mexico	630,211	50,976	7.9	11.8
Arizona	654,511	95,976	8.6	10.1
Utah	676,909	11,953	7.3	10.4
Nevada	149,907	10,176	10.0	12.6
Pacific				
Washington	2,316,495	62,468	9.3	9.9
Oregon	1,497,128	24,213	9.2	11.5
California	9,947,000	639,000	9.4	8.0

[1] Population figures from 1950 Census of Population, Preliminary Reports: Total U.S. and District of Columbia, Series PC-7, No. 1; States, including District of Columbia, Series PC-12, Nos. 1-49.

[2] Crude rates. Source for 1948 deaths: National Office of Vital Statistics, U.S. Public Health Service. Rates based on 1950 enumerated populations and 1948 deaths.

Maternal mortality for Negroes has decreased from 12.8 in 1920 to 2.4 in 1949; among whites, from 7.6 in 1920 to 0.7 in 1949. Infant mortality for Negroes has decreased from 135.6 in 1920 to 46.8 in 1949; among whites, from 82.1 in 1920 to 28.9 in 1949. Stillbirth rates in the table are not complete, but a general decline for the total population is shown.

Mortality by Separate States: Table 2 shows population and death rates for the United States and separate states, according to region and by race. It will be noted that, with few exceptions, the higher death rates for nonwhites, mostly Negroes, are in states where there is the greatest concentration of Negro population. Mortality among Negroes in some states with small Negro populations may be influenced by other factors, such as living and working conditions in urban centers.

Mortality from Selected Causes: Table 3 shows crude death rates for a large number of specific causes per 100,000 of the population, by race, for the period 1919-48.

Most diseases show varying degrees of decline for the period 1939-41 to 1948, but rates for heart disease, cancer, diabetes, puerperal causes (total), and diarrhea, enteritis, and ulceration of intestines have increased in both races. Exceptions noted are a decline in rates for cancer of the breast among both whites and nonwhites, and for cancer of female genital organs among whites, and in rates for intracranial lesions of vascular origin, which are slightly down for nonwhites and up for whites.

Table 4 shows crude mortality rates per 100,000 of the population for 10 selected causes arranged by race and rank, for the year 1948. It will be noted that categories for all races are the same, except that homicide and syphilis for whites, and motor vehicle accidents and diabetes for nonwhites, are not in the first 10 causes of death.

Tuberculosis: The trend for tuberculosis is shown in Table 5. This table presents a graphic picture of the effective treatment and control of this disease in the period 1910-48. However, the death rate for the nonwhite population is still approximately two and one-half times that of the white population.

Life Expectancy: Table 6 shows the expectation of life at birth and at age 40 in the United States, according to color and sex, for selected periods from 1900 to 1944. With slight fluctuation in some periods, the over-all gain at birth for white males is 17.7 years and for white females 20.4 years; for nonwhite males 26.0 years and for nonwhite females 27.9 years.

TABLE 3

MORTALITY TRENDS FOR SPECIFIC CAUSES, BY RACE, 1919-1948

(Crude Death Rates per 100,000 Population [1])

Cause of Death	Nonwhite				White			
	1919–21	1929–31	1939–41	1948	1919–21	1929–31	1939–41	1948
Diphtheria	8.7	5.6	1.9	.75	16.7	5.4	1.1	.35
Scarlet fever	.82	.70	.26	.03	4.57	2.25	.53	.05
Whooping cough	17.7	11.2	6.7	2.55	8.2	4.3	2.0	.55
Tuberculosis (all forms)	250.9*	191.7	126.4	78.7	92.1	58.1	36.5	24.3
Cancer and other malignant tumors	48.9	56.9	76.2	98.4	87.7	101.9	124.0	139.1
Cancer of digestive organs and peritoneum	20.0*	22.8	30.4	40.5	47.5	51.8	57.7	60.4
Cancer of the breast	9.9*	10.6	13.6	8.0	16.1	19.3	24.0	13.6
Cancer of female genital organs	30.8*	33.8	37.8	38.3	24.5	27.5	31.2	30.8
Pneumonia (all forms)	160.7	140.1	91.4	66.4	107.7	79.1	49.7	35.4
Diseases of the heart	160.7	217.6	239.2	263.3	157.7	212.4	290.8	330.1
Intracranial lesions of vascular origin	86.7	104.9	109.7	108.9	91.5	87.1	86.8	87.4
Nephritis (all forms)	110.5	133.5	120.3	84.4	84.3	85.0	75.0	49.3
Syphilis (all forms)	40.9	51.6	52.3	27.1	14.9	11.6	9.9	5.7
Diabetes mellitus	7.5	12.7	17.3	18.3	16.7	20.2	26.8	27.3
Pellagra	18.2	28.9	6.3	.95	1.3	2.4	1.1	.40
Malaria	22.4	13.8	5.6	.50	1.9	1.6	.60	.10
Puerperal causes (total)	12.0	11.6	7.4	17.4	7.0	6.1	3.1	4.2
Premature birth	24.3	19.5	17.6	43.0	18.4	16.3	13.2	24.8
Injury at birth	2.2	3.1	3.6	—	3.9	5.0	4.5	—
Congenital malformations	3.1	2.3	2.3	10.9	6.5	5.8	5.0	13.4
Diarrhea, enteritis, ulceration of intestines	18.3	10.6	6.4	10.4	14.4	6.8	3.4	5.5
Hernia and intestinal obstruction	12.1	12.7	11.3	8.4	10.3	10.1	8.7	6.7
Ulcer of the stomach and duodenum	4.1	6.0	6.2	4.4	4.0	6.2	6.8	6.1
Suicide	4.1	5.0	4.3	4.1	12.0	16.6	14.9	12.1
Motor vehicle accidents	5.2	22.0	25.3	20.9	10.8	26.9	27.1	22.3
Other accidents	70.2	62.4	51.0	50.3	59.0	52.3	45.9	44.4
Homicide	—	40.0	34.2†	30.6	—	5.6	3.2†	3.0

Source: National Office of Vital Statistics, U.S. Public Health Service.

[1] Average of rates for males and females.

* For 1920-21, except for digestive organs (1921).

† For 1939.

TABLE 4

MORTALITY FROM TEN SELECTED CAUSES, BY RACE AND RANK, 1948 [1]

(Crude rate per 100,000 population)

Nonwhite			White		
Rank	Cause of Death	Rate	Rank	Cause of Death	Rate
1	Diseases of the heart	263.3	1	Diseases of the heart	330.1
2	Intracranial lesions of vascular origin	108.9	2	Cancer and other malignant tumors	139.1
3	Cancer and other malignant tumors	98.4	3	Intracranial lesions of vascular origin	87.4
4	Nephritis (all forms)	84.4	4	Nephritis (all forms)	49.3
5	Tuberculosis (all forms)	78.7	5	Accidents (except motor vehicle)	44.4
6	Pneumonia	66.4	6	Pneumonia (all forms)	35.4
7	Accidents (except motor vehicles)	50.3	7	Diabetes mellitus	27.3
8	Premature birth	43.0	8	Premature birth	24.8
9	Homicide	30.6	9	Tuberculosis (all forms)	24.3
10	Syphilis (all forms)	27.1	10	Motor vehicle accidents	22.3

Source: National Office of Vital Statistics, U.S. Public Health Service.

[1] See Table 3 for changes 1919 to 1939-41.

TABLE 5

DEATH RATES FOR TUBERCULOSIS (ALL FORMS) BY RACE AND SEX, 1910-1948 [1]

Year	Total	White			Nonwhite		
		Total	Male	Female	Total	Male	Female
1948	30.0	24.3	33.3	15.4	78.7	92.1	65.4
1944	41.3	33.7	45.0	23.3	106.2	122.7	91.3
1943	42.6	34.3	44.4	24.7	112.9	126.4	100.0
1942	43.1	34.4	43.3	25.6	118.4	131.4	106.0
1941	44.5	35.4	43.3	27.4	124.2	134.3	114.5
1940	45.8	36.5	44.7	28.2	127.6	138.7	116.9
1935	55.1	44.9	51.7	37.8	145.1	155.4	135.0
1930	71.1	57.7	63.4	51.9	192.0	194.3	189.8
1925	84.8	71.6	75.8	67.2	221.3	215.8	226.7
1920	113.1	99.5	104.1	94.8	262.4	255.4	269.6
1915	140.1	128.5	144.0	112.2	401.1	420.2	380.5
1910	153.8	145.9	158.2	132.8	445.5	479.3	406.8

Source: Division of Chronic Disease and Tuberculosis and National Office of Vital Statistics, U.S. Public Health Service.

[1] Rates for death registration states.

Average remaining lifetime in years at specified ages, by race and sex, in the United States for the years 1949 and 1948 is shown in Table 7.

There is a significant difference in the life span for whites and nonwhites. Life expectancy at birth among white males in 1949 exceeded that for nonwhite males by 7.3 years. Among white females the excess was 8.6 years over nonwhite females.

These tables are unmistakable evidence of what a progressive nation can do to improve and extend the lives of its people.

TABLE 6

LIFE EXPECTANCY AT BIRTH AND AT AGE 40 IN U.S., ACCORDING TO COLOR AND SEX, SELECTED PERIODS, 1900 TO 1944

Year or Period	Birth				Age 40			
	White		Nonwhite[1]		White		Nonwhite[1]	
	Males	Females	Males	Females	Males	Females	Males	Females
1944[2]	63.55	68.95	58.30	58.99	30.39	33.97	26.26	28.92
1943[2]	63.16	68.27	54.65	57.97	29.97	33.47	25.83	28.11
1942[2]	63.65	68.61	54.28	58.00	30.27	33.86	25.92	28.51
1939-1941[2]	62.81	67.29	52.26	55.56	30.03	33.25	25.06	27.19
1930-1939[2]	60.62	64.52	50.06	52.62	29.57	32.24	24.65	26.11
1929-1931[2]	59.12	62.67	47.55	49.51	29.22	31.52	23.36	24.30
1920-1929[3]	57.85	60.62	46.90	47.95	29.35	30.97	24.55	24.67
1919-1921[3]	56.34	58.53	47.14	46.92	29.86	30.94	26.53	25.60
1909-1911[4]	50.23	53.62	34.05	37.43	27.43	29.26	21.57	23.34
1901-1910[4]	49.32	52.54	32.57	35.65	27.55	29.28	22.23	23.81
1900-1902[4]	48.23	51.08	32.54	35.04	27.74	29.17	23.12	24.37
Gain: 1900-02 to 1949[5]	17.7	20.4	26.0	27.9	3.16	6.13	4.08	6.03

Note: Life table fsor 1944, 1943, and 1942 prepared in Statitsical Bureau of Metropolitan Life Insurance Company; for 1944 on basis of unpublished data furnished by U.S. Bureau of the Census.
[1] Data for periods from 1900-31 and 1939-41 relate to Negroes only.
[2] Continental U.S.
[3] Registration States of 1920.
[4] Original Death Registration States.
[5] See Table 7.

TABLE 7

LIFE EXPECTANCY: AVERAGE REMAINING LIFETIME (IN YEARS) AT SPECIFIED AGES BY RACE AND SEX, U. S., 1949 AND 1948

Age	Total Population	1949				Total Population	1948			
		White		Nonwhite			White		Nonwhite	
		Males	Females	Males	Females		Males	Females	Males	Females
0	67.6	65.9	71.5	58.6	62.9	67.2	65.5	71.0	58.1	62.5
1	68.8	67.1	72.3	60.8	64.7	68.4	66.8	71.9	60.2	64.2
5	65.2	63.5	68.7	57.5	61.3	64.9	63.2	68.3	56.9	60.8
10	60.4	58.7	63.9	52.8	56.5	60.1	58.4	63.5	52.1	56.1
15	55.6	53.9	59.0	48.0	51.7	55.2	53.6	58.6	47.4	51.3
20	50.9	49.3	54.2	43.5	47.1	50.6	49.0	53.8	42.9	46.8
25	46.3	44.7	49.4	39.3	42.8	46.0	44.4	49.0	38.7	42.5
30	41.7	40.0	44.6	35.1	38.5	41.3	39.8	44.3	34.6	38.3
35	37.1	35.4	39.9	31.0	34.3	36.8	35.2	39.6	30.5	34.2
40	32.6	30.9	35.3	27.2	30.4	32.3	30.7	35.0	26.8	30.3
45	28.3	26.7	30.8	23.6	26.8	28.0	26.5	30.5	23.3	26.7
50	24.2	22.6	26.4	20.5	23.5	24.0	22.4	26.2	20.1	23.4
55	20.4	18.9	22.3	17.7	20.4	20.2	18.8	22.0	17.5	20.3
60	16.8	15.5	18.3	15.3	17.7	16.6	15.4	18.1	15.2	17.6
65	13.5	12.4	14.6	13.1	15.5	13.4	12.4	14.4	13.1	15.5
70	10.7	9.8	11.3	11.8	14.4	10.6	9.8	11.2	11.5	14.3
75	8.2	7.5	8.5	10.5	13.2	8.1	7.5	8.3	10.3	13.2
80	6.0	5.5	5.9	9.4	12.2	5.9	5.4	5.8	9.2	11.9
85	4.0	3.7	3.7	8.1	10.9	3.9	3.6	3.7	7.6	10.3

Source: National Office of Vital Statistics, U.S. Public Health Service.

In them, too, are indications of unmet needs among the nonwhite population, which, as fulfilled, will accelerate the trend to a uniform rate for all.

Data concerning life expectancy published August 1951 in the *Statistical Bulletin* of the Metropolitan Life Insurance Company, show that in 1950 the expectation of life at birth for the industrial policy-holders of this company reached an all-time high of 68.3 years, an increase of fully half a year over the figure for 1949. The gain has amounted to 5⅓ years since 1940 and to 21⅔ years since 1911-12, when life expectancy at birth in the wage-earning population was 46.6 years. The *Bulletin* stated:

> Each color and sex group in this insurance experience has shared in the improvement in longevity in the past decade, but not in equal measure. Among both the white and the colored, females have a more favorable record than males. Among white persons at age 20, for example, the increase in average remaining life-time between 1940 and 1950 was 3.7 years for females and 2.8 years for males. For the colored, among whom the corresponding gains were even greater, the increases were 5.4 years for females and 5.0 years for males. This greater gain for the colored than for the white has narrowed somewhat the disparity between the two groups. Nevertheless, the whites still have a marked advantage over the colored in expectation of life.

NEGROES IN ALLIED MEDICAL PROFESSIONS

Most of the private medical, dental, and nursing care of Negroes in the United States is rendered by members of the Negro race. This practice within the race has not been by choice, though race consciousness and increased confidence in Negro doctors have increasingly contributed to the selection of a Negro doctor by the Negro patient. The major factor has been racial attitudes and customs in some parts of the nation which restrict residence and activities of both lay and professional members of the Negro group. For the Negro doctor, the choice has been one of professional and economic survival.

There is a great need for more and better training facilities to provide more doctors and nurses and a more equable distribution of them to meet the demands for adequate health and medical services in many communities, urban and rural. The greatest concentration of doctors of both races is in large cities, which offer the best facilities for practice and the most satisfying living conditions for the doctor and his family.

Physicians[1]

Table 8 shows the total number of all physicians and of Negro physicians, by region and state, with ratio of physicians to units of the population.

The total of all physicians in the United States, not including those in government services, in 1950 was 193,205, with a ratio of 780 persons per physician. The estimated number of Negro physicians for the year 1948, (latest detailed data available), was 3,753, with a ratio of 3,681 Negro persons per Negro physician. This 1948 ratio is approximately correct for the year 1950, since there have been only enough Negro medical graduates to compensate for the loss of Negro physicians and for the proportionate increase in Negro population. Hence, there are nearly five times as many Negro persons per Negro physician as there are total persons, white and nonwhite per physician in the total number of physicians in the United States.

The largest deficiency is manifest in those areas where comparable educational, economic, and cultural conditions are unfavorable for all persons but particularly for the Negro. For example, the number of persons per physician in the total population of the Southern states was 1,146 in the year 1948. In other regions the number was much less, varying from 520 in the Middle Atlantic states to 867 in the East North Central states.

[1] Sources: American Medical Directory, 1950; *The Journal of Negro Education*, Yearbook Number 18, Summer 1949, "The Health Status and Health Education of Negroes in the United States." Communication from Michael J. Bent, Dean, School of Medicine, Meharry Medical College, "Distribution of Negro Medical Students in the United States."

TABLE 8

TOTAL POPULATION-PHYSICIAN RATIOS; NEGRO POPULATION RATIOS FOR NEGRO PHYSICIANS AND NEGRO DENTISTS; AND NUMBER OF NEGRO PHYSICIANS AND NEGRO DENTISTS IN U.S. FOR SELECTED YEARS

Region and State	Total Number Persons Per Physician[1]	Total Number Negro Persons Per Negro Physician[1]	Total Number Negro Physicians[1]	Total Number Negro Persons Per Negro Dentist[2]	Total Number Negro Dentists[2]
South	1,146	6,203	1,572	15,859	584
Virginia	1,262	4,453	168	10,499	63
North Carolina	1,556	5,739	178	16,632	59
South Carolina	1,706	12,561	68	20,354	40
Georgia	1,158	7,384	147	21,699	50
Florida	1,035	4,403	145	13,185	39
Kentucky	1,224	2,323	91	7,380	29
Tennessee	1,078	2,352	233	6,875	74
Alabama	1,036	8,519	116	25,876	38
Mississippi	1,525	18,132	57	37,054	29
Arkansas	1,104	10,830	44	17,873	27
Louisiana	743	10,052	92	23,592	36
Oklahoma	984	1,701	100	8,887	19
Texas	1,046	7,828	133	11,412	81
Border States and District of Columbia	691	1,808	425	5,142	125
Delaware	876	3,341	12	7,175	5
Maryland	719	3,496	102	10,411	29
West Virginia	1,035	1,827	65	4,529	26
District of Columbia	370	1,029	246	2,881	65
New England	658	1,668	68	2,051	49
Maine	878	—	—	—	—
New Hampshire	751	548	1	—	—
Vermont	831	—	—	—	—
Massachusetts	598	1,496	41	1,846	30
Rhode Island	680	1,870	6	3,675	3
Connecticut	685	1,910	20	2,062	16
Middle Atlantic	520	2,564	533	3,837	330
New York	496	2,723	222	3,995	143
New Jersey	366	2,386	109	4,053	56
Pennsylvania	697	2,487	202	3,742	131
East North Central	867	1,709	707	4,005	267
Ohio	907	2,222	172	4,297	79
Indiana	946	1,852	76	3,810	32
Illinois	711	1,615	263	3,459	112
Michigan	1,032	1,339	185	6,114	38
Wisconsin	943	1,203	11	2,026	6
West North Central	850	1,265	294	4,875	72
Minnesota	730	3,920	3	1,986	5
Iowa	967	1,838	10	4,174	4
Missouri	718	1,111	231	5,200	47
North Dakota	1,236	—	—	—	—
South Dakota	1,396	—	—	—	—
Nebraska	876	934	15	2,834	5
Kansas	1,093	2,024	35	5,922	11
Mountain	734	3,283	13	5,202	7
Montana	786	—	—	—	—
Idaho	706	—	—	—	—
Wyoming	1,233	—	—	—	—
Colorado	619	2,136	6	3,044	4
New Mexico	1,300	5,139	1	4,672	1
Arizona	664	3,320	6	7,497	2
Utah	658	—	—	—	—
Nevada	728	—	—	—	—
Pacific	624	1,374	141	3,629	37
Washington	1,032	3,316	3	3,712	2
Oregon	1,016	3,252	1	—	—
California	538	1,319	137	3,552	35
United States	780	3,681	3,753	8,745	1,471

Sources: *Journal of Negro Education*, Yearbook Number 18, Summer 1949, "The Health Status and Health Education of Negroes in the United States." *The Journal of the American Dental Association*, June 1, 1947, "Distribution of Negro Dentists in the United States."

[1] Year 1948, latest figures available for comparison.

[2] Year 1940, population Census figures and number of Negro dentists in 1940 are used for comparison. 1950 figures are not available; estimate of population ratios for 1950 is about the same as 1940 figures.

Among Negroes, in 1948; the ratio in the Southern states was 6,203 Negro persons per Negro physician; in other regions, the number ranged from 1,265 in the West North Central states to 3,283 in the Mountain states. It is apparent that the differences are both regional and racial.

The total number of medical graduates from all approved medical schools in the United States, July 1, 1950, to June 30, 1951, was 6,135. The number of Negro medical graduates in 1950-51 was 143, assuming that all enrolled senior Negro medical students graduated. There is encouragement in the slight but significant increase in the total enrollment of Negro medical students from 653 in 44 of the 72 approved medical schools in 1949-50 to 661 in 45 of these schools in 1950-51 (not including Temple University, which had 9 Negro students in 1949-50 but for which 1950-51 figures are not available). Whereas 518 of the 661 Negro medical students were in Howard University College of Medicine and Meharry Medical College School of Medicine, the other 143 were enrolled in 43 mixed institutions, admitting white and colored students. In 1938-39, there were only 45 Negro medical students enrolled in mixed schools.

Pharmacists

Data for pharmacists, recognized as an important member of the medical service team, are not available. There is a large number of Negro pharmacists, many of whom are proprietors of modern drug stores. Some operate pharmacies limited to prescription service only.

Dentists[1]

Conditions similar to those affecting Negro physicians are presented in statistics of professional dental training and available dental services for Negroes. The total of all dentists in the United States in 1950 was 84,301 (not including dentists in government services), with a ratio of 1,777 persons of the total population per dentist. Table 8 shows the number of Negro dentists and the Negro population to Negro dentist ratios for the year 1940. The ratio in 1940 was 8,745 persons per Negro dentist. The U.S. ratio of population to dentists was 1,865.

In 1945, a total of 1,533 Negro dentists was reported, a gain of 4.2% over the year 1940. However, this slight increase was approximately proportionate to the increase in the Negro population for the same period. The estimated number of Negro dentists in 1950 was 1,650, with a ratio of 9,383 Negro persons per Negro dentist. The number of Negro persons per Negro dentist is more than five times the number of persons in the total population (white and nonwhite) per dentist in the total number of dentists in the United States. There is approximately the same ratio between Negro dentists and Negro persons, and Negro physicians and Negro persons. Also it is noted that the Negro population ratio in the Southern states is greater for Negro dentists than it is for Negro physicians. And, as for all dentists, white and Negro, the greatest concentration is in the larger cities, which offer more attractive conditions for practice and better community life.

The trend toward a larger number of students enrolling in dental schools is encouraging in view of the need of many more dentists to meet the demands for adequate dental care. The Negro has shared this increase to some extent in recent years through admission of Negro students to dental schools which formerly did not admit them. More than three-fourths of all Negro dental students are enrolled in Howard University and Meharry Medical College Schools of Dentistry, which have trained and graduated most of the Negro dentists in the United States.

Nurses[2]

Recent data on Negro nurses as a separate group in the total number of profes-

[1] Sources: American Dental Directory, 1950 (American Dental Association). *The Journal of Negro Education*, Yearbook Number 18, Summer 1949, "The Health Status and Health Education of Negroes in the United States."

[2] Source: "1950 Facts about Nursing" (A Statistical Summary).

sional nurses are not available except in a few categories.

The National Association of Colored Graduate Nurses, professional organization of Negro nurses, was discontinued with the integration of Negro nurses in the American Nurses Association of the United States and state affiliates, including most of the southern states.

A statistical summary of professional nurses for January 1, 1950, reports a total of 506,050 in the year 1949. The estimated number of Negro nurses was 9,000. The number of Negro students in nursing schools was 3,076. During 1949, a total of 1,383 Negro students were admitted to schools of nursing and 507 were graduated. The number of schools admitting Negro students increased from 76 in 1946 to 207 in 1950.

HOSPITALS[1]

Passage of the Hospital Survey and Construction Act in August 1946 by the U.S. Congress, which was implemented by Federal-state appropriations, has given great impetus to the provision of needed hospital beds. The plans of the state hospital commissions must conform to regulations issued by the Surgeon-General of the U.S. Public Health Service and the Federal Hospital Council. A Negro hospital administrator is a technical member of the Council.

This hospital program has materially changed the outlook for adequate hospital facilities for the nation's population, including the Negro, on an equable basis. To be eligible for Federal aid under the act, a hospital must either accept Negro patients or give assurance that separate hospital facilities will be available for Negroes in the area. Moreover, these separate facilities must be equal to the proportion of the Negro group in the total population of the area. For example, suppose a community with a population of 50% white and 50% colored has 100 hospital beds, 30 of which are for Negroes and 70 for whites. If the state survey indicates that the community needs 100 additional beds, the state plan must provide 70 beds for Negroes and not over 30 beds for whites.

The chapter on "Hospital Services for Negroes" in the report of the Commission on Hospital Care in the United States (The Commonwealth Fund, 1947) contains the following recommendations:

1. That adequate and competent hospital care should be available without restriction to all people regardless of race, creed, color, or economic status.
2. That facilities for the care of Negro patients should be provided in hospitals that serve white patients rather than in separate hospitals. In those communities in which segregation is required by law, as good hospital service should be maintained for Negro patients as is provided for white patients.

Figures for all hospital beds in the United States as of Jan. 1, 1951 (number of existing beds, net additional beds, and total beds needed), by geographical region, are recorded, but the number of beds allocated specifically for Negroes is not available. Many conditions influence Negro bed capacity in hospitals, north and south. Even in states where segregation is legally required, data are not constant because of regulatory policies and, primarily now, because of hospital facilities progressively becoming available under the Hospital Survey and Construction Act. In the North, too, policy and custom often determine the occupancy of beds by Negroes.

Many surveys of Negro hospitals have been made, but the figures produced vary to such extent that they are not dependable. For example, one survey of 124 Negro hospitals in 23 states in 1944[2] recorded less than 10,000 beds. A later listing of beds in Negro hospitals in 1947[3] reported 20,336 beds in 105 hospitals. Partial returns from a preliminary survey of Negro hospital beds by the Office of Negro Health Work, Public Health Service, 1948-49, show the following results: Now in use—beds, 33,390; bassinets, 1,000. Under construction—beds, 1,515; bassinets, 185. Planned—beds, 8,781; bassinets, 839. These figures do not include a large number of beds occupied by Negroes in mental and tuberculosis hospitals. The range in numbers of beds in hospitals listed was from a few beds in some individual proprietary hospitals or clinics to hundreds in some corporate and community hospitals and thousands in some state and municipal hospitals.

TABLE 9

PARTIAL LIST OF NEGRO HOSPITALS APPROVED FOR FEDERAL CONSTRUCTION FUNDS UNDER HILL-BURTON PROGRAM

Hospital	Estimated Total Cost	Approved Federal Share
Blessed Martin de Porres Hosp., Mobile, Ala.	$ 611,425	$ 195,475
Florida A.&M. College Hosp., Tallahassee, Fla.	1,923,119	641,039
Americus Sumter Colored Hosp., Americus, Ga.	199,400	109,670
Grady Memorial Hosp., Negro Unit, Atlanta, Ga.	1,717,984	1,030,790
Provident Hosp. Training School, Chicago, Ill.	527,000	204,476
Community Hosp., Evanston, Ill.	940,000	364,720
Red Cross Hosp., Louisville, Ky.	650,964	423,476
Lincoln Hosp., Durham, N.C.	758,000	333,520
St. Agnes Hosp., Raleigh, N.C.	86,356	36,924
Good Samaritan Waverly Hosp., Columbia, S.C.	219,249	129,102

Source: Hospital Facilities Division Report, Oct. 31, 1951, Federal Security Agency, Public Health Service.

Note: The designation "Negro hospital" is not the policy or the practice of the Federal Security Agency and Public Health Service. However, Negro hospitals are eligible for Federal construction funds if these hospitals meet the requirements for approval.

Most of these smaller hospitals do not meet the standards prescribed for approval, but many of the larger and better hospitals do meet all requirements.

Three major factors will determine the completion of the projected hospital program for the nation: Appropriated monies, availability of building materials, hospital equipment, and supplies, and the time necessary for the construction and occupancy of hospitals. But there is assurance that within a reasonably short period there will be a hospital bed for every need.

A very important factor in the hospital situation is the lack of opportuniites for Negro professional persons on the medical, surgical, and supervisory staffs of hospitals, even in hospitals in the South which maintain separate facilities for Negroes. There have been some gains, north and south, but a more liberal policy and practice are necessary to provide these opportunities on the basis of merit not restricted by consideration of race.

Partial List of Negro Hospitals With Fifty Beds or More[1]

Brewster Hospital
Jacksonville, Fla.
Burrell Memorial Hospital
Roanoke, Va.
Charity Hospital
Savannah, Ga.
Collins Chapel Connectional Hospital
Memphis, Tenn.
Community Hospital
Wilmington, N.C.
Douglass Hospital
Kansas City, Kans.
Edith K. Thomas Memorial Hospital
Detroit, Mich.
Fairview Sanitarium
Detroit, Mich.
Flint-Goodridge Hospital of Dillard University
New Orleans, La.
Florida A. & M. College Hospital
Tallahassee, Fla.
Freedmen's Hospital
Washington, D.C.
George W. Hubbard Hospital of Meharry Medical College
Nashville, Tenn.
Georgia Infirmary
Savannah, Ga.
Good Samaritan Hospital
Selma, Ala.
Good Samaritan Hospital
Charlotte, N.C.
Good Samaritan-Waverly Hospital
Columbia, S.C.
The Good Shepherd Hospital
New Bern, N.C.
Homer G. Phillips Hospital
St. Louis, Mo.

[1] Source: "What the Hospital Act Means to Negroes," *National Negro Health News*, Public Health Service, Vol. 15, No. 2, April-June 1947.
[2] Source: "Health Hospitals, and the Negro," *Modern Hospital*, August 1945; "Communication on Hospitals for Negroes," American Medical Association, Jan. 6, 1947.
[3] American Medical Association, Jan. 6, 1947.

[1] Taken from a list of 132 hospitals of record. The larger number of Negro hospitals have less than 50 beds. Most of the larger and some of the smaller Negro hospitals are members of the National Conference of Hospital Administrators. These hospitals do not incude those which admit and serve Negro patients in the same buidings and not in separate Negro units. In some hospitals Negro patients are restricted tc oertain areas—wings, floors, or wards. Some hospitals having a majority of Negro patients and staff members are called *interracial hospitals*.

Houston Negro Hospital
Houston, Texas
John A. Andrew Memorial Hospital
Tuskegee Institute, Ala.
Kansas City General Hospital No. 2
Kansas City, Mo.
Kate Bitting Reynolds Memorial Hospital
Winston-Salem, N.C.
L. Richardson Memorial Hospital
Greensboro, N.C.
Lincoln Hospital
Durham, N.C.
Mary Lawson Sanatorium
Palatka, Fla.
Mercy-Douglass Hospital
Philadelphia, Pa.
Norfolk Community Hospital
Norfolk, Va.
Parkside Hospital
Detroit, Mich.
Peoples' Hospital
St. Louis, Mo.
Prairie View State College Hospital
Prairie View, Texas
Provident Hospital and Free Dispensary
Baltimore, Md.
Provident Hospital and Training School for Nurses
Chicago, Ill.
Red Cross Hospital
Louisville, Ky.
St. Agnes Hospital
Raleigh, N.C.
St. Mary's Infirmary
St. Louis, Mo.
Searcy Hospital
Mount Vernon, Ala.
Tampa Negro Hospital
Tampa, Fla.
Trinity Hospital
Detroit, Mich.
Veterans' Administration Hospital
Tuskegee, Ala.
Wayne Diagnostic Hospital
Detroit, Mich.
Wheatley-Provident Hospital
Kansas City, Mo.
Whittaker Memorial Hospital
Newport News, Va.
William A. Harris Memorial Hospital
Atlanta, Ga.

PUBLIC HEALTH

Although the Negro people have been beneficiaries of many procedures and practices of public health, they have not shares the available facilities or opportunities in a measure comparable to their needs.

In recent years more facilities have been provided Negroes both in separate and in integrated services; and some qualified Negro individuals have been trained in public health and placed in useful and responsible positions. Although very limited in number, there are Negro doctors, nurses, and technical and clerical personnel in official health departments and health centers, voluntary health agencies, school health systems, and other organizations which employ health workers. The largest number of Negroes employed in public health activities are nurses. Doctors are relatively few, and most of their service is in clinics. Schools employ a considerable number of Negro physicians, dentists, dental hygienists, and nurses. The number of Negro health educators is growing. In recent years fellowships available from various sources for training in health education were available in part to qualified Negro applicants. No funds have been available from voluntary sources in the past few years, but state departments of health may use Federal-state funds for the training of qualified persons who will be employed by that state's health department upon completion of training.

National Negro Health Movement

One of the most active and productive agencies for the improvement of the health of the Negro was the National Negro Health Movement, the year-round extension and development of National Negro Health Week, founded in 1915 by Booker T. Washington. At that time, Dr. Washington inspired public and private agencies to join forces in an effort to improve the health of the Negro people through education in healthful living. Information was disseminated through churches, schools, civic groups, and health agencies. One week in April, covering Dr. Washington's birthday, was set aside for intensive effort. National Negro Health Week became a rallying point for sponsoring and participating groups and agencies and for program evaluation.

In 1930, the Annual Health Week Conference passed a resolution establishing the program on a year-round basis and changing the name to the National Negro Health Movement. Health Week, however, continued to be observed. An executive committee, composed of a representative from each of the sponsoring agencies (Tuskegee Institute, Howard University, the National Medical Association, and the National Negro Insurance Association), was formed to plan the program and activities. From 1932 to 1950, the Public Health Service supported the National Negro Health Movement, supplying staff, facilities, and materials for nation-wide activities recommended by the executive committee.

The program of the Movement had 10 major objectives:

1. Consultation with state health officers to learn at first-hand the public health problems relating to the colored population.
2. Contact with states and local Negro organizations to secure their aid in promotion of the health the Negro and their support of measures sponsored by state and local health authorities.
3. Stimulation of the training and employment of Negro public health personnel by state and local health departments and other agencies.
4. Consistent efforts to elevate the standards of training for Negro personnel and to induce persons with good educational background and aptitude to fit themselves for public health work.
5. Special efforts to emphasize health work in Negro schools and to encourage the employment of trained personnel for health work in the schools.
6. Maintenance of a comprehensive register of speakers qualified to give talks on public health subjects.
7. Establishment in the central office of the National Negro Health Movement of a list of qualified Negro health workers.
8. The development of a depository of health information relating to the colored population, to include an abstracting and reference section.
9. Analysis of Census data and vital statistics to determine the distribution of population and the nature and extent of health problems.
10. Promotion of National Negro Health Week as a period for emphasis on the general health status of the Negro population and the program for health improvement.

The Office of Negro Health Work of the Public Health Service was an outgrowth of the program. It was discontinued in 1950 in keeping with the policy and practice of integration prescribed by the Administrator of the Federal Security Agency and directed by the Surgeon-General of the Public Health Service. It was succeeded by the Special Programs Branch, whose duties are concerned with all minority groups and intercultural relations during the transition from separate health activities by race to uniform, comprehensive health programs for all people without racial distinction.

Dr. Roscoe C. Brown and other personnel of the Division of Public Health Education, Public Health Service, will continue to give consultative services to Negro groups in their communities. The Special Programs Branch will continue to serve as a clearing-house of information on state and community health programs, health education materials, and programs available for Negro groups.

The National Negro Health News, published since 1933 as the medium for program promotion and recording of data on the health of the Negro, was discontinued with the April-June 1950 issue. Data of the kind formerly published in this periodical will be issued in publications which cover larger areas of the organization and activities of the Public Health Service.