

Population Ecology and the Racial Integration of Hospitals and Nursing Homes in the United States

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POPULATION ECOLOGY IS CURRENTLY A PROMINENT paradigm in the study of organizations. It focuses on explaining the effect of environmental change on the characteristics of organizational populations (Aldrich 1979; Carroll 1983; Pfeffer and Salancik 1978). Two premises distinguish this perspective:

1. *Ecological determinism*: Environmental pressures dictate how organizations change and which ones will survive.
2. *Structural inertia*: Organizations have limited capacity to change. Thus, change results primarily from the selection and retention over time of those organizations best adapted to new ecological conditions.

As a framework for understanding organizational change, population ecology is analogous to natural selection in biology. Change in an organizational environment, no less than change in a biological one, produces shifts in the diversity, characteristics, and relative population sizes of the biological species or organizations existing therein.

Others (Alexander, Kaluzny, and Middleton 1986; *Medical Care Review* 1987) have reviewed much of the literature on population ecology and its implications for health-services organizations. One observation is that externally imposed changes resulting in increased competition,

greater regulation, and more centralized systems of reimbursement produced the growth of multi-institutional systems. In this changed environment, multi-hospital systems showed a clear advantage over free-standing hospitals (Kaluzny and Hernandez 1988; Starr 1982). Thus, according to the population ecology perspective, free-standing facilities over time will not survive or will be absorbed into larger multi-institutional systems. Similarly, the population of medical practices has shifted toward large single- and multi-specialty groups (Rundall 1987).

This article assumes a population ecology perspective to explore the impact of new environmental pressures in the 1960s to integrate racially hospitals and nursing homes in the United States. It will evaluate how the presence or absence of ecological determinism and structural inertia affected change in these facilities.

I argue that, in spite of the seemingly universal environmental pressures toward integration, the distinctive ecological niche of nursing homes left them more insulated than hospitals from these pressures. Consequently, greater discrepancies between black and white access and a greater degree of racial segregation has continued. In contrast, the ecological niche of hospitals underwent a more dramatic transformation, resulting in the closure of most historically black hospitals.

Background

The efforts to integrate health-care facilities in the United States in the 1960s produced significant changes in the organization of health care. Acute-care hospitals in all regions of the country abandoned policies to provide racially segregated services. Although most gaps between black and white mortality and morbidity remained unchanged, differentials in access to health care between blacks and whites narrowed significantly (Manton, Patrick, and Johnson 1989).

These improvements in access are often assumed to have been a by-product of the passage of the Medicare and Medicaid programs. One could argue, however, that the Medicare and Medicaid programs were, at least in part, by-products of the civil-rights struggle. The strong, sustained economic growth in the United States during the 1960s raised expectations for expanded social services. Improvements in access to health care for blacks had begun to take place well before the implementation of the Medicare and Medicaid programs. The largest percent

increase in real per capita health expenditures in the United States, in fact, appears to have been in 1964 and the second largest in 1965 (Getzen 1990; Office of Economic Cooperation and Development 1985). With the passage of the Civil Rights Act, the year 1964 became the high water mark of the civil-rights movement, yet the first full year of operation for the Medicare and Medicaid programs did not take place until 1967.

The changes produced by the efforts to integrate health facilities have received little attention in studies of the civil-rights movement. Only a few articles and monographs in medical or health-services-related publications describe the course of these events (Beardsley 1986; Halperin 1988; McBride 1989). On the surface, a seemingly instantaneous change took place. As one black physician in Georgia noted, his white colleagues "acted like it was never any different, like segregation had never existed" (Beardsley 1986, 386).

Until the 1960s, however, racial segregation was extensive in all forms of health services. Eighty-five percent of the southern hospitals in a 1963 survey by the U.S. Civil Rights Commission reported at least some type of racial segregation (U.S. Civil Rights Commission 1963, 141). These estimates were remarkably similar to those reported in two surveys: one conducted by the Urban League in 1955 and another by the Southern Conference Educational Fund in 1951 (Cornely 1957; *Southern Patriot* 1952, 2). In June 1951, the major hospital trade journal, *Modern Hospital*, published a series of articles on segregation and urged a voluntary end to such practices (Cunningham 1951), but this had little impact on existing patterns of care. Black hospitals existed throughout the South and in most larger northern cities in part because of racial barriers to medical-staff privileges at white hospitals. In Philadelphia, for example, until the 1960s one black hospital essentially provided the only place where black physicians could gain privileges and where black medical-school graduates could obtain internships and residencies (McBride 1989).

The federal Hill-Burton program did little to change existing local patterns of racially segregated care and medical-staff privileges. Beginning in 1946, the program financed massive construction of acute-care hospitals in the United States. By 1963, the program had helped provide nearly one million beds, expending close to \$2 billion (U.S. Department of Health, Education and Welfare 1963). The federal government specified detailed requirements in the applications for these funds, as-

sureing, among other conditions, that state plans provide for "adequate hospital facilities for people residing in a state without discrimination on account of race, creed or color" (U.S. Civil Rights Commission 1963, 103). However, the Hill-Burton program offered an exception to this in "cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group" (U.S. Civil Rights Commission 1963, 130).

This "separate but equal provision" continued into the 1960s. Meanwhile, 14 southern and border states planned racially separate hospitals with Hill-Burton funds. By the end of 1962, Hill-Burton administrators had awarded grants of \$37 million for construction or remodeling of 89 racially exclusive facilities (U.S. Civil Rights Commission 1963, 131).

Racial segregation in health facilities, however, did not exist just in the South or border states alone. The New York State Advisory Committee to the United States Civil Rights Commission in 1964 identified the following discriminatory practices in seven Buffalo nonprofit and charitable hospitals:

Hospital A: Concentration of Negro patients in one wing; Negro maternity cases are restricted to one particular floor; Negro doctors are excluded from both the active and courtesy staff; Negro applicants have been denied admission to the nursing school.

Hospital B: Negro patients are excluded from two floors; Negro patients experience continual difficulty in obtaining requested accommodations.

Hospital C: Negro patients excluded from the new wing of the hospital.

Hospital D: Color matching segregation by rooms and areas in maternity.

Hospital E: Negro patients are excluded from the new section of the hospital.

Hospital F: Color matching in maternity area.

Hospital G: Negro employees excluded from dietary department. (New York State Advisory Committee 1964, 10)

Five of the seven hospitals, moreover, had recently received or applied for Hill-Burton funds. A Chicago survey reported that, even though almost half the black population had some form of private hospital in-

surance, blacks represented less than 1 percent of the patients in Chicago's private hospitals and more than 50 percent of those in Cook County (*Southern Patriot* 1955, 3). These cases from Buffalo and Chicago illustrate patterns of racial segregation commonly found in many areas up until the mid 1960s. These were mostly informal practices that segregated racially medical staffs, employees, and patients in many communities.

Hospital Hill-Burton project applicants wishing to construct racially separate facilities, for example, first filled out a form stating:

No person/certain persons (cross out one) in the area will be denied admission to the proposed facilities as patients because of race, creed or color (U.S. Civil Rights Commission 1963, 131).

If they crossed out "no person," the state agency had to complete a separate form stating that:

The requirement of nondiscrimination had been met because this is an area where separate facilities are provided for separate population groups and the State plan otherwise makes equitable provision, on the basis of need for facilities and services of like quality for each such population group in the area (U.S. Civil Rights Commission 1963, 131).

These provisions did not assure equal access. For example, North Carolina built 27 hospitals with Hill-Burton funds exclusively for whites and four for blacks (U.S. Civil Rights Commission 1963, 132). The North Carolina plan projected beds available by race. It included those beds neither receiving Hill-Burton grants nor having any relation to the state other than licensing. Each year the plan showed that the total number of beds was proportionately equal to the population by race in each reporting area. There was no requirement that the Public Health Service, which administered the federal Hill-Burton program, independently establish the validity of these assertions. In Charlotte, which was North Carolina's largest city in 1960, for example, the major hospital provided 437 beds to whites and only 38 to blacks. Only one other hospital provided a limited number of beds for nonwhites, although the city's population was about 24 percent black (Halperin 1988, 61). These numbers did not suggest separate but equal access to care; the quality of services provided did not compare well, either. In Wilmington, North Carolina, one hospital maintained a separate

building 30 yards from the main hospital with 24 beds for blacks. Patients were transported through the open space outside to surgery and other laboratory facilities (Halperin 1988, 61).

If blacks had limited and segregated access to acute care in many areas of the country, it was probably better than their access to long-term-care facilities. With the emergence of the modern hospital in the twentieth century, long-term care evolved into a separate sector. Nursing homes developed as institutions providing care to either publicly or privately sponsored patients rather than to a broader geographic community, as many voluntary hospitals did. Beginning in the late 1930s, local welfare commissioners, wishing to make their limited funds reach as far as possible to serve their charges, would contract with private boarding homes. This practice assured that Old Age Assistance subsidies, prohibited under Social Security legislation from being awarded to individuals housed in "institutions," were available (Thomas 1969).

Yet, the result was a segregated two-class system of care. Services for welfare recipients were provided in private boarding homes and county facilities, whereas those able to afford care were predominantly accommodated in voluntary homes with religious affiliations or in private facilities designed for the same clientele. Private-pay blacks were largely excluded from the predominantly private-pay voluntary homes and from at least those private homes for welfare recipients run for whites. There was little available for blacks with limited financial resources. The county facilities were crowded and generally designed to discourage use, even if including accommodations for blacks.

Bishop noted in her 1948 study of Philadelphia, which at the time included 52 licensed nursing homes, that "the need for nursing home care for indigent Negroes is practically unmet. Only three homes now accommodate Negro recipients on assistance, although Negroes constitute one-fourth of the old-age assistance case load in the city" (Bishop 1946, 17).

Changing the Population Ecology of Health-care Facilities

Two key court rulings, along with the passage of the civil-rights, Medicare, and Medicaid legislation, changed the ecological niche of hospitals and nursing homes. An ecological "niche" is a resource combination

that supports a particular organizational form (Aldrich 1987, 272). As far as institutional health services are concerned, that niche includes: (1) the community a facility serves, (2) the medical staff that admits the members of that community as patients, (3) third parties and the relative generosity of their payments for the patients admitted, and (4) public regulatory bodies that ultimately control the flow of these resources to the facility. As will become evident, these sources of environmental support had a far greater stake in the integration of hospitals than of nursing homes.

The impetus for changes, as the population ecology perspective would predict, came from outside the facilities. The niche occupied by such facilities shifted and many of the older patterns of organization were no longer viable. Both civil-rights efforts and efforts to expand access to health care shared in the prosperous environment following World War II that made some progressive measures possible. During the 1960s, the United States experienced sustained growth in real per capita income averaging almost 3 percent per year, unmatched by any previous decade in the century. Although interrupted by several recessions, strong growth in per capita income was also achieved in the 1950s. As any participant in collective-bargaining negotiations knows, there is less friction in extracting concessions when the overall economic pie is expanding.

Another force for change was World War II, which provided a major environmental jolt to the way many Americans looked at their own society. Jim Crow laws and practices had too many similarities with the practices and underlying ideologies of racial supremacy of Germany and Japan. The Nazi concentration camps were a vivid, universally repugnant example of the ultimate consequence of such views. Many individuals among the more than one million returning black servicemen served as catalysts for change over the next two decades (Hampton and Fayer 1990, xxiv). Cold War competition with the Soviet Union also made the United States government increasingly sensitive to the image produced by obvious racial inequalities.

The two organizations most directly involved in the struggle to integrate hospitals racially were the National Association for the Advancement of Colored People (NAACP) and the National Medical Association (NMA). The history of the development of these two organizations provides a useful illustration of the population ecology paradigm. Each emerged and occupied a distinctive ecological niche. As environmental

conditions changed, their structures limited their effectiveness in achieving their goals, triggering the emergence of new organizations better adapted to these changed conditions.

The NAACP, founded in 1909, was from its inception interracial in composition with a predominantly northern base of support (Clark 1966). The NAACP coordinated its activities among three components. The national NAACP handled political action affecting national policy. Local chapters, with diverse orientations and leadership reflecting their local environments, assumed responsibility for efforts to combat discriminatory practices in local communities. The NAACP Legal Defense and Educational Fund, however, was the component most directly involved in the hospital integration struggle. Launched as an autonomous body in 1939 to allow for tax-deductible contributions, the Fund had by the 1950s established its own offices, staff, board, and budget. The lawyers on the staff forged a strategy of protracted court challenges that eventually led to a major victory with the unanimous Supreme Court decision on education in 1954. Similar victories were achieved by this same staff in a series of subsequent court challenges of discriminatory practices in hospitals.

The NAACP relied mostly on the dues and contributions of its members to fund its activities. This membership was predominantly northern, black, and middle class, including many physicians who were also members of the NMA. The goals of the organization reflected the aspirations of its membership. For the most part, they wanted full inclusion of blacks in the existing social and political structure rather than more basic changes.

The NMA, however, had the most direct and pressing interest in the hospital integration problem. Founded in 1895 at the height of the imposition of Jim Crow practices in the South, it grew to include some 60 local medical organizations across the country (Cobb 1951, 325). In most respects, it mirrored the structure of the American Medical Association (AMA). The local medical societies composing the NMA's membership were formed as a result of exclusion of blacks from local constituent medical societies of the AMA. Beginning in the 1930s, members of the NMA became increasingly concerned with the problem exclusion posed for them. The medical-staff by-laws of most hospitals stipulated that appointments would be made only from members in good standing with the local medical society. Exclusion from these local medical societies blocked any chance of gaining staff privileges at white

hospitals. Black physicians were thus far more likely than black patients to face restrictions in access to hospitals. As the practice of medicine became increasingly hospital dependent, access to hospitals became an increasingly critical problem. "Unless the Negro doctor can find some way to integrate himself into the hospital organization," one black physician noted in an address to the New Jersey State Medical Society in 1940, "it is not beyond the pale of probability for the changing social order or new way of life to force him face to face with bankruptcy" (Brown 1942, 85). "Full access to modern hospital facilities," the *Journal of the National Medical Association* (JNMA) observed in 1946, "is the number one problem facing half of our doctors" (*Journal of the National Medical Association* 1946, 35).

Members of the NMA were often divided on whether to press for full integration or to develop separate facilities. Whereas the NAACP opposed segregation on principle, many black physicians just wanted a place to practice medicine. Looking at possible postwar construction planning in 1945, the JNMA concluded that, although complete integration of hospitals in the North may be an achievable goal, irrevocable lines in the South had been drawn and the only choice was to support the construction of separate hospitals (*Journal of the National Medical Association* 1945, 28).

Until about 1950, the NMA had relied largely on voluntary persuasion of their white peer professional organizations to achieve their goals. A "Good Will Committee" formed in 1938 had successfully persuaded the AMA in 1940 to delete the special notation, "(Col.)," that appeared in their directory after the names of black members (Bowles 1939; *Journal of the National Medical Association* 1940, 171-72). It took another ten years of politicking through more sympathetic AMA constituent societies to prompt the organization to acknowledge the problem black physicians faced in formally joining many local medical societies. The House of Delegates at their 1950 meeting approved a resolution urging that "constituent and component societies that have restrictive membership provisions based on race study this question *in the light of prevailing conditions* [italics added], with a view to taking steps as they may elect to eliminate such restrictive provisions" (*Journal of the American Medical Association* 1950, 1086). Even this concession, falling far short of addressing the NMA's concerns, seemed partly motivated by the AMA's need to close ranks in their battle to block the Truman Administration's proposal for national health insurance. The

1949 convention of the National Medical Association had come close to endorsing the Truman proposal, and its president had taken exception to the AMA's viewpoint, insisting that the NMA should do its own thinking and be concerned "with the masses of the poor and needy people who do not have adequate medical care" (*Journal of the National Medical Association* 1949, 233; 1953).

A similar effort in voluntary peer persuasion aimed to convince the Association of American Medical Colleges (AAMC) to adopt a statement of principle against racial discrimination in medical-school admissions. At its annual meetings between 1947 and 1950, the AAMC rejected this attempt, reaffirming their position of noninterference in the admissions policies of their member colleges (*Journal of the National Medical Association* 1951, 57). Meanwhile, blacks were admitted to the University of Arkansas and Texas medical schools following a series of victories in the Supreme Court in cases brought by the NAACP Legal Defense Fund.¹ "Lamentable as it may be," the JNMA noted, "the indication is plain that we must look more to the courts than voluntary sources for correction of discriminatory practices in professional education" (*Journal of the National Medical Association* 1951, 58).

By 1953, the NMA and NAACP had adopted a joint strategy for achieving integration in health care. Their conclusions were the same as those the federal government reached for controlling health-care costs some 25 years later. First, integration would need ultimately to be a legally enforceable requirement, rather than relying on voluntary effort and collegial good will. Second, the hospitals themselves, rather than their medical staffs or local medical societies, would be the focus of moral, legal, and legislative pressure. They were potentially more amenable to public control. This indirect approach had the added advantage of minimizing the ill will of local white practitioners who could one day have black physicians as colleagues.

The strategy, formulated by the National Health Program of the NAACP, was adopted at its 1953 convention and endorsed that same year by the NMA convention (Cobb 1953). W. Montague Cobb, editor of the JNMA, served as chair of the National Health Committee of the

¹*Missouri ex rel. Gaines v. Canada*, 305 U.S. 337 (1938); *Sipuel v. Board of Regents*, 332 U.S. 631 (1948); *Sweatt v. Painter*, 339 U.S. 629 (1950). The NAACP first chose an indirect assault in forcing the integration of state professional schools through court rulings to assure equal programs for blacks (Miller 1966).

NAACP, which formulated the program. Focusing on hospitals, the NAACP strategy called for NAACP branch health committees to make initial contacts with medical facilities and express the desire for voluntary cooperation to end discriminatory practices. Efforts to gain local media coverage of the program were to follow. Where persuasion and educational efforts failed, local groups were to be responsible for collecting the documentation necessary to evaluate strategies for obtaining legislative and legal remedies. Two outgrowths of these activities, detailed below, were a series of court challenges led by the NAACP Legal Defense Fund, and a series of national conferences jointly organized by the NAACP and NMA to focus national attention on the problem and possible legislative redress.

External events—predictable from a population ecology perspective—soon overwhelmed this carefully articulated strategy. The JNMA heralded the May 17, 1954 date of the unanimous Supreme Court *School Desegregation* decision as equivalent in the “annals of freedom” to the Declaration of Independence and the storming of the Bastille (*Journal of the National Medical Association* 1954, 269).² The lack in the executive branch of a clearly expressed will to enforce the decision and its broader implications, and the largely effective massive southern white resistance, soon shattered expectations for quick redress (Ashmore 1988, 206–36; Garrow 1986; Goldfield 1990, 63–86). Although continuing to achieve some token successes, hospital integration stalled as did other efforts at integration.

New organizations, radically different in structure and better adapted environmentally to deal with this new stalemate, emerged as largely spontaneous protests spread across the South. The NAACP and NMA were limited-membership organizations and, as such, not well suited to coordinating mass protests. Martin Luther King’s Southern Christian Leadership Council (SCLC) arose in the wake of the Montgomery Bus Boycott in December 1955 and similar boycotts soon followed in other cities. SCLC was a loose coalition of local organizations with few staff and no formal membership. The organization thrived on crisis and even took perverse pride in administrative chaos (Fairclough 1981, 231). Unlike the support by fees of the NAACP and NMA memberships, SCLC gathered its funding from a sympathetic national audience, who learned of SCLC protests through the media.

²*Brown v. Board of Education*, 347 U.S. 483 (1954).

A second new organization, the Student Non-Violent Coordinating Committee (SNCC), was formed in 1960 following another wave of spontaneous demonstrations. Black college students organized sit-ins at southern lunch counters in at least 69 communities (Oppenheimer 1989, 94). For the youthful, fully committed SNCC member, direct action became a way of life, culminating in the Freedom Rides of the following year and voter-registration drives across the deep South. SNCC, at least in its early years, represented the extreme in antibureaucratic organizations. Local groups reached decisions by consensus rather than voting. Operations were highly decentralized and ideologically averse to any centralized leadership (Stoper 1989, 71). Such a structure and philosophy were well adapted to overcoming local resistance to "outsiders" in many southern community-organizing activities.

The lack of formal structure and the high degree of spontaneity in both SCLC and SNCC made them effective in this new environment. Tactical innovation was easier. Such innovation added to the difficulties of local authorities in neutralizing the protests and helped keep the issues they raised in the national media spotlight (McAdam 1983). The roles in the civil-rights struggle of the older, more formally structured NAACP and NMA now shifted to peripheral ones of limited support rather than initiators of action.

The NAACP-NMA efforts to integrate hospitals, however, moved forward almost unnoticed in the wake of the more tumultuous events of this period. Key activists in this coalition included two black physicians at Howard University, Paul Cornely and W. Montague Cobb. Cobb, as editor of the *JNMA*, produced editorials and news on the "Integration Battlefront" that heightened members' awareness and resolve. Cornely gained the support of the American Public Health Association, linking the social problems with public-health problems, as had most previous public-health reform movements. He argued that "segregation and discrimination are environmental factors and are just as damaging to health as water pollution, unpasteurized milk or smog" (Cornely 1956, 1081).

In 1957, Cobb initiated the Imhotep Conferences, an annual national series aimed at ending segregation of medical care. None of the major professional associations (American Hospital Association, the American Medical Association, the Catholic and Protestant Hospital Associations) sent delegates to the first conference and neither the Department of Health, Education and Welfare nor Howard University was

willing to provide space (Beardsley 1986, 375). Participation waned after the 1957 conference. However, the conferences' goal of a fully integrated health-care system eventually won the endorsement of both Presidents Kennedy and Johnson, due in part to the strong support that the NMA, in contrast to the AMA, had provided in the early 1960s to pending Medicare legislation.

During this same period, the NAACP Legal Defense Fund began a series of court appeals, in conjunction with some local NMA physicians and NAACP health committees. The key cases involved attempts to redefine hospitals as an "arm of the state." Viewed as quasi-public bodies, these appeals argued, hospitals involved in discriminatory practices violated the equal-protection provisions of the Fourteenth Amendment. The first case involved three black physicians whose application for "courtesy staff" privileges at Walker Hospital in Wilmington, North Carolina had been denied in 1955. In 1958, the U.S. District Court dismissed their complaint.³ The city, in the court's view, had donated the land for the restricted purpose of operating the hospital. Both the city and county had a contract with the hospital to provide indigent care. However, the court concluded that such arrangements did not define the hospital as a state body. Consequently, the hospital's actions could not be reviewed in the light of the Fourteenth Amendment. Specifically, the court in *Eaton* concluded that such arrangements did not carry with them any public control of the hospital and thus the hospital's act of discrimination did not constitute a state action.

A similar suit initiated in 1962, however, appeared to reverse the *Eaton* decision. A protracted effort by George C. Simkins, Jr., and other colleagues to obtain privileges at the two white hospitals in Greensboro resulted in denial (Chafe 1980, 155-56). The physicians and dentists brought suit, with two patients claiming that the hospitals abridged their rights. Specifically, the suit contended that: (1) the facilities had received Hill-Burton funds for construction according to the state's Hill-Burton plan, (2) the hospitals were thus "instruments of the state," and (3) the portion of the act allowing for separate-but-equal facilities for medical care was unconstitutional under the due-process, equal-protection provisions of the U.S. Constitution. The plaintiffs failed to gain a favorable ruling at the U.S. District Court level. How-

³*Eaton v. Board of Managers of James Walker Memorial Hospital*, 262 F.2d 521 (4th Cir. 1958). *cert. denied*, 359 U.S. 984 (1959).

ever, in 1963 the U.S. Court of Appeals, in a three-to-two vote, reversed this decision.⁴ The majority opinion concluded that the hospitals were sufficiently involved with the state and federal governments to fall within the constitutional prohibition against racial discrimination. The Supreme Court refused to hear the appeal and allowed the decision of the lower court to stand. The Surgeon General immediately issued new strict nondiscrimination regulations for those facilities applying for Hill-Burton funds.

The black physicians in the Eaton case filed a second suit in 1960. The earlier Eaton decision was overturned in light of the Simkins decision by the United States Court of Appeals in 1964.⁵ The federal courts had also developed a more clearly defined and broadened scope of inquiry where state action was alleged. In addition, new evidence was presented on the public capital-construction subsidies provided the hospital. The court concluded that the preponderance of the evidence suggested that the hospital was performing the state's function and was its chosen instrument. As a consequence, it argued, James Walker Hospital was bound by the provisions in the Fourteenth Amendment to refrain from the discrimination alleged in the case.

Although some hospitals had not received Hill-Burton funds, almost all acute-care hospitals had received at least some state or local public support for indigent care and for capital projects, and thus could be similarly construed to be bound by the amendment's provisions. In circulating the decision to his members, the executive secretary of the Virginia Hospital Association noted, "[I]t would appear that segregation of any kind in our nation's hospitals is old-fashioned and rapidly being struck down by the courts" (*Hospitals* 1964, 183).

In 1964 the efforts of the Imhotep conferences also reached fruition with the passage of the Civil Rights Act. Title VI of the act made the implications of the earlier court decisions for federal programs clear:

No persons in the United States shall, on the grounds of race, color or national origin, be excluded from participation in or be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.⁶

⁴*Simkins v. Moses H. Cone Hospital*, 323 F. 2d 959 (4th Cir. 1963), cert. denied, 84 U.S. 793 (1964).

⁵*Eaton v. Grubb* 329 F.2d 710 (1964).

⁶Civil Rights Act of 1964, Section 601, 42 U.S.C. Section 2000d (1981).

The federal government subsequently adopted an enforcement strategy whose blueprint was remarkably similar to the one adopted by the NAACP-NMA coalition over a decade earlier. At the insistence of President Lyndon Johnson, the Department of Health, Education and Welfare convened its own "final Imhotep Conference," or Conference on the Elimination of Hospital Discrimination on July 17, 1964. All the major medical and hospital trade associations, in contrast to the Imhotep Conferences, were officially represented. DHEW Secretary Celebrezze expressed the President's hope that understanding the requirements of the law would avoid unnecessary controversy and litigation and would produce speedy voluntary compliance (Cobb 1984, 47).

The Medicare and Medicaid legislation in 1965 dramatically raised the cost of resistance. In order to receive a provider contract with the Medicare program, facilities had to comply with Title VI. The Office of Equal Health Opportunity in the Public Health Service was responsible for certifying compliance.

The implication of these events, however, was more significant for the ecological niche of hospitals than nursing homes because the stakes in achieving Title VI compliance were much higher for hospitals. The impact of these events on the four key sources of facility support is summarized in table 1.

The threat of loss of federal funds to hospitals was a potent one. All of the hospitals' key environmental sources of support had a stake in quick accommodation to the new antidiscrimination requirements. Failure to meet these requirements meant (1) beneficiaries would be unable, at least in their local community, to take advantage of their Medicare entitlement, (2) the medical staff would lose a major source of income, (3) no funds would be available through the Medicaid program to care for the indigent, and (4) the hospitals would face catastrophic financial losses. In addition, federal government regulators were insulated from local influence and faced no financial disincentives for rigorous enforcement.

With this shift in the ecological niche, the risk of integration to the white-controlled individual hospitals was minimal. There would be no flight of white professional staff or loss of white-patient market share because other hospitals in their market would face the same requirements. The hospitals would receive cost-based reimbursement from Medicare and Medicaid for many of their new black patients and thus faced less financial risk than before. Restrictive eligibility criteria and

TABLE 1
The Ecological Niche of Hospitals and Nursing Homes:
The Stake of Key Resources in Title VI Compliance

Key resources	Hospitals	Nursing homes
General community (patients)	Medicare payment for the care of all persons over 65	Medicaid payment for the care of the indigent
Medical staff (referrals)	Active involvement; a major source of practice income	Limited involvement; a minor source of practice income
Third-party payers (reimbursement)	Medicare full-cost payments; few self-paying patients	Medicaid offers less attractive payments; many self-paying patients
Regulators (approvals to operate)	Federal accountability; enforcement fiscally budget neutral	State accountability; substantial fiscal implications for state government

payments for hospitals occurred in some state Medicaid programs, particularly in the South, but did not create the same magnitude of problems that such arrangements created for nursing homes. For the white, racially separate hospitals, integration offered the opportunity for almost risk-free expansion of their market. For the racially segregated hospitals, it offered risk-free elimination of costly duplication of services.

The impact of these changes on the ecological niche of nursing homes was less significant. Their key environmental sources of support were not as threatened by these changes. Only indigents in the community might lose access to benefits. Medicare and Medicaid payments for the care of nursing-home patients constituted only a marginal portion of incomes of most medical staff. Similarly, Medicare's restrictive eligibility for long-term-care benefits produced little income for nursing homes. Nursing homes preferred almost all other forms of payment to the stringent reimbursement of most state Medicaid programs.

States did not anticipate the rapid increases in the cost to them of their Medicaid programs. While the proportion of these costs going for long-term care varied from state to state, the total percent of Medicaid

costs for long-term care grew from 34.9 percent in 1973 to 43.8 percent in 1982 (Health Care Financing Administration 1986, 17), representing the largest and most rapidly growing component of the cost in these programs. Control of these costs quickly became a major focus of state governments (Holahan and Cohen 1987). Greater access for black Medicaid patients meant increasing the cost of the Medicaid program. Thus, nursing homes faced little sustained pressure to integrate from state regulatory bodies. Any initiative to increase the racial integration of their facilities constituted a substantial risk to individual nursing homes because their private-paying white patients, who were crucial to their financial viability, could be lost to less progressive homes.

Hospitals and nursing homes adapted quickly and instinctively to the changes in their ecological niche in predictable ways. Standard operating procedures quickly reflected the consequences of this adaptation, as did the relative degree of racial access and integration of facilities.

The Process of Adaptation

During the 1960s, hospital and community leaders feared that riots and picketing, particularly in racially tense communities in the South, might erupt from carrying out the requirements of the Civil Rights Act for health facilities. None happened. In many southern communities, blue-ribbon committees emerged, determined to smooth the transition (Beardsley 1986, 381–82). Community leaders, whatever their attachment to segregation, preferred integration to open conflict. In speaking to the American Hospital Association at their annual meeting in September 1965, Assistant Secretary for Health James Quigley said that many administrators welcomed the Civil Rights legislation and the opportunity it gave them to work with their boards in ending discriminatory practices. Quigley noted, however, that there were exceptions:

We have, for example, listened to explanations that no Negro babies were in the nursery because all the Negro mothers preferred to nurse their babies—therefore all Negro babies “roomed-in” with their mothers.

We have met men who said they no longer segregate Negro patients; they now *reserve* a section of the hospital especially for Negroes (thus implying preferential treatment, incidentally). We have had hospital administrators state that Negroes were *not required* to

use special entrances and exits of the hospital but *prefer* to use the entrance that used to have a sign marked "Colored."

We have had a spokesman for the community tell us that no Negro was willing to serve on the Board of Directors of a community hospital because no Negro was public spirited enough to accept such an assignment. . . .

One institution removed "Colored" and "White" signs from their rest rooms and installed locks on the doors—and then issued keys only to white staff. And—as perhaps the ultimate step in our education to date—one hospital deliberately placed Negro and white patients in the same rooms, closed the Negro dining room and integrated the nursery for the benefit of a review team—and then promptly shifted everything back to business as usual as soon as the review team left the city (Quigley 1965, 457–58).

The federal enforcement effort, however, did not go into full effect until the spring of 1966. It focused on certifying hospital compliance with Title VI as a condition of participation in the Medicare program. Hospitals were among the first recipients of federal assistance to undergo Title VI compliance reviews. By July 1, 1966 the staff of the Office of Equal Health Opportunity in the Public Health Service, which had been established in February 1966 to review hospitals for Medicare certification, had grown to 600 persons (H. Bennett, personal communication, October 13, 1989). Between March 1 and July 1, 1966, the Office of Equal Health Opportunity conducted 4,142 compliance reviews. President Johnson received a daily report concerning the number of facilities still not brought into compliance (H. Bennett, personal communication, October 13, 1989). One North Carolina community, with a separate black and white hospital, telegraphed the Office asking, "What should we do to comply?" "Merge" was the telegraphed reply. They quickly converted the black hospital to a nursing home (F. Weil, personal communication, October 24, 1989).

The Johnson Administration demonstrated the same concern for the integration efforts as for the Vietnam conflict and viewed the efforts to integrate Medicare as a major domestic political mine field. Public pronouncements to the contrary, many key officials doubted the wisdom of using the Medicare program to force instantaneous integration. The success of the integration efforts was a relief and a surprise (H. Bennett, personal communication, October 13, 1989). Only 130 hospitals failed to be certified by the beginning of the Medicare program on July 1, 1966.

By 1968, the activities had been reorganized into the Office for Civil

Rights. Federal involvement had been largely relegated to reviewing the state agencies responsible for Title VI. However, in January 1968 the acting director of the Office for Civil Rights could report that "97 percent of all hospitals in the nation were officially committed to non-discriminatory provision of services. Of this total, more than 3,000 changed previous policy and practices to comply with Title VI. As of January 1968, only 12 hospitals had lost federal funds because of failure to comply with Title VI" (U.S. Civil Rights Commission 1970, 47).

A few hospitals with severe structural inertia resisted. The federal government initially withheld approval for Medicare funds from only 118 facilities (H. Bennett, personal communication, October 13, 1989). By the end of the decade, funds were subsequently terminated from only 14 hospitals (U.S. Civil Rights Commission 1980, 433). Loss of or inability to obtain Medicare certification would guarantee bankruptcy within six months for almost all facilities, and thus provided a powerful incentive for quick accommodation.

Roper Hospital in Charleston, South Carolina demonstrated both the degree of structural inertia required to resist federal pressures and the determination of the Justice Department. Roper's chief of staff had recommended opening the facility to black admissions in order to qualify for federal funds. However, the South Carolina Medical Society, which owned the facility, refused. The Justice Department sued the facility, not only to integrate its facilities, but also to end discriminatory hiring practices. Its cafeteria and snack bar served visitors from other states and thus fell under the provisions of the Interstate Commerce clause. Such places of public accommodation were subject to the 1964 Civil Rights act (Beardsley 1986).

Local civil-rights groups continued to be critical of the slow pace and lack of resources placed in enforcement. The NAACP Legal Defense Fund in 1966 sharply criticized the federal failure to cut off funds from more hospitals (Meltsner 1966). However, the Office for Civil Rights worked closely with local civil-rights groups, often relying on them instead of field staff to observe and test local discriminatory practices. The efforts of the civil-rights groups, pressure from federal officials, and the willing collaboration of local medical, hospital, and community leaders produced a quiet and seemingly effortless transformation. Subsequent reports of the Civil Rights Commission note with satisfaction the rapid progress in the integration of acute-care hospitals (U.S. Civil Rights Commission 1971).

Hospitals traditionally serving black patients, however, were now

forced to compete in the same niche with previously white hospitals. Many did not survive. As the executive director of the Hospital Planning Council of Metropolitan Chicago noted, “[T]he negro hospital is dead. The Civil Rights Act killed it” (Foster 1967, 114). Hospitals with formerly all-white medical staffs aggressively recruited black physicians and their patients followed. White physicians who had previously used these facilities for their black patients ceased to do so. Black hospitals for the first time faced direct competition for physicians and patients with generally larger, better endowed institutions. Panels of experts, recruited by the federal government, toured communities to help them in deciding what to do with these facilities (Sigmond 1985). Between 1964 and 1984, 49 traditionally black hospitals closed. An additional 13 merged with white facilities or converted to other purposes (Wesley 1984). In Philadelphia one hospital, Mercy-Douglass, which had provided the almost exclusive site of hospital practice for black physicians through the mid 1960s, experienced a decline in occupancy and a worsening financial condition, which led to its closing in 1973 (Gamble 1989). It was converted to a nursing home and currently operates with about a 90 percent nonwhite census. Other hospitals such as Provident Medical Center, the oldest black-owned hospital and the only remaining one in Chicago, succumbed in 1987 after a similar protracted struggle (*American Medical News* 1987). Others that have traditionally served black communities continue to be among the most financially troubled acute-care facilities in the country. In 1944 at least 124 black hospitals operated in the United States. By the end of 1989 only eight remaining historically black hospitals continued operations (Wesley 1989, 62–63). Thus, it was not clear to many local black leaders whether the black community was gaining or losing through integration.

In contrast, progress was slower in the integration of nursing homes. Because funding of nursing-home care came predominantly through state Medicaid programs, nursing homes were not subjected to the crash federal compliance reviews of the hospitals. The Johnson Administration was more ambivalent in its approach to nursing homes than to short-stay hospitals (H. Bennett, personal communication, October 13, 1989). They perceived a large difference in the level of contact between blacks and whites required in long-term-care facilities as opposed to hospitals. Nursing homes, they felt, were people’s homes and not just places where they received brief medical treatment. The only real change that was effectively enforced, one official conceded, was to re-

quire the replacement of statements of racially or religiously exclusionary admissions practices with a statement in promotional materials describing an admission policy "without regard to race, color, creed or national origin" (H. Bennett, personal communication, October 13, 1989). The Civil Rights Commission regularly noted this lack of progress and was increasingly critical of the Department of Health, Education and Welfare's efforts (U.S. Civil Rights Commission 1971; 1973). The Institute of Medicine, in its own review of the civil-rights issues related to the provision of health services in 1981, focused special attention on nursing homes and found the alternative explanations for the low use of nursing homes by blacks inadequate (Institute of Medicine 1981, 7).

Although many southern communities focused on integrating their hospitals, most paid little attention to integrating their nursing homes, in part due to their smaller size, larger proportion of private ownership, and lack of active medical staff involvement. While the new Medicare and Medicaid regulations closed many older wood-frame facilities for life-safety violations, no homes were closed because of competition for patients from newly integrated white facilities. Many of the closed black hospitals were converted to nursing homes and continued to provide care to a predominantly black clientele.

Impact on Racial Access and Facility Integration

Access. Figure 1 summarizes the convergence of black acute hospital discharge rates to white rates and the large gap that continues to exist between elderly black and white use rates in nursing homes. Whereas the 1985 white/black ratio of age-adjusted hospital discharge rates, excluding deliveries, was .91, the white/black ratio of elderly use rates of nursing homes was 1.36. Adjusting for age, the likelihood of a white person being discharged from a hospital was .91 times that of a black person. In contrast, an elderly white person was 1.36 times as likely to be a resident in a nursing home as an elderly black person.

Two general measures of access are routinely reported by the Medicare program: (1) the proportion of enrollees receiving services (persons served per enrollee) and (2) reimbursement per enrollee. Figure 2 presents the ratio of elderly white to nonwhite values on these two measures for hospital and nursing-home services. Although the Medi-

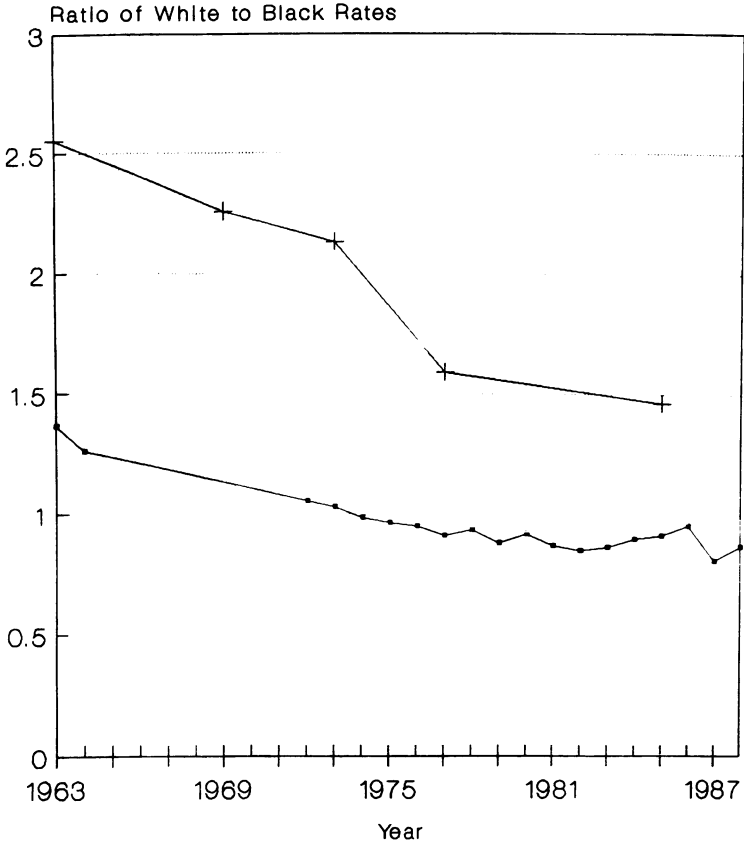


FIG. 1. Ratio of white to black use of hospitals and nursing homes in the United States (1963-1988). □ = hospital discharge; + = nursing-home use.

Sources: Hospital discharge rates are from the National Health Interview Survey, age adjusted, including only live discharges and excluding deliveries (National Center for Health Statistics 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1989a, 1990). The 1964 estimate combines nonwhites with blacks. Nursing-home use rates are estimated from the National Nursing Home survey for persons 65 years or older (Hing 1987, 3; National Center for Health Statistics 1987, 154). The 1963 and 1969 estimates of nursing-home use rates combine nonwhites with blacks.

care program offered uniform benefits to both blacks and whites, a large gap persisted between the actual benefits that white and nonwhite elderly enrollees obtained in 1967, the first full year of the program. By 1984, the ratio of white to nonwhite persons served per enrollee and reimbursement per enrollee for inpatient hospital care dropped to 1.08 and .9, respectively. However, in 1984 the ratio of

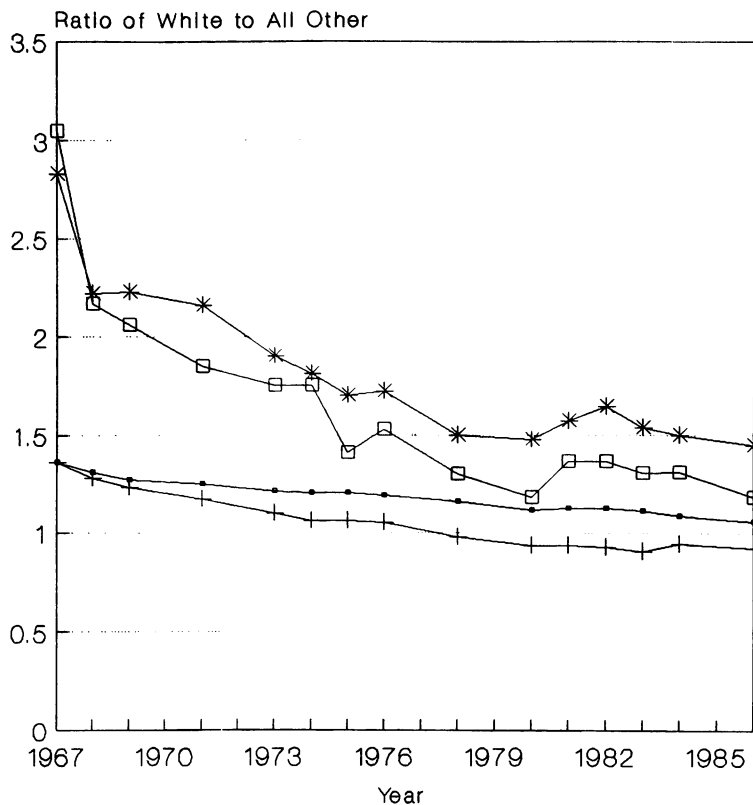


FIG. 2. Ratio of white to all other races of Medicare services and reimbursement per aged enrollee (1967-1986). □ = hospital care; * = nursing-home care; + = hospital payment; □ = nursing-home payment.

Sources: Office of Statistics and Data Management, Health Care Financing Administration (Ruther and Dobson 1981; Health Care Financing Administration 1982, 1983, 1986, 1987, 1989). 1986 estimates are from the Health Care Financing Administration's Bureau of Data Management and Strategy. Racial designation is derived from forms completed by beneficiaries. Nonwhites are predominantly black persons, except in a few western states.

white to nonwhite persons served per enrollee and reimbursement per enrollee for nursing-home care was 1.50 and 1.16, respectively.

The nonwhite population has higher morbidity rates and higher consumption of inpatient resources per admission, as reflected in the greater convergence of white and nonwhite reimbursement per beneficiary (Manton, Patrick, and Johnson 1989; Munoz et al. 1989). Thus,

measures of crude access rates to hospitals and nursing homes overestimate the degree of equality in access.

Medicaid is the major third-party payer of nursing-home services in the United States. In 1985, Medicaid was the primary source of payment for 50.4 percent of all nursing-home residents. A remaining 41.6 percent of nursing-home residents relied on their own or family resources as the primary source of payment (National Center for Health Statistics 1989, 55). Although in 1985 blacks constituted 31 percent of the Medicaid recipients and accounted for 21.8 percent of Medicaid expenditures nationally, they comprised 8 percent of the recipients and accounted for 8.9 percent of the expenditures for skilled nursing facilities (Health Care Financing Administration 1989, 85).

The striking differences in black and white use of nursing homes have long been noted. The Institute of Medicine stated in their 1981 review of the research that "most persons who have studied and written about black use of nursing homes believe that racial discrimination is a major explanatory factor" (Institute of Medicine 1981, 98). The Institute's own review looked at three alternative explanations of these differences: (1) underlying differences in morbidity and disability rates, (2) differences in family values and living arrangements, and (3) differences in geographic and economic access. Their analysis, supported by subsequent studies, suggests that at least the first two alternative explanations are implausible.

First, as observed by the Institute of Medicine (1981) and supported in subsequent studies, the black elderly as a whole have significantly higher rates of morbidity and disability than the white elderly. On this basis, one would expect higher rather than lower rates of nursing-home use. The proportion of white Medicare enrollees with functional impairment living in the community is .66 of the nonwhite proportion (Macken 1986, 37). In contrast to life expectancy at birth, the gap in life expectancy between blacks and whites at age 65 has widened since 1960 (Manton, Patrick, and Johnson 1989, 137).

The second alternative explanation, differences in family values and living arrangements, is more difficult to rule out. Certainly the availability of informal caregivers, family preferences, and extended family and community ties play a far more significant role in determining admission rates to nursing homes than to hospitals. Family values, such as the relative importance of the role played by the elderly in black family life and the value placed on kinship ties and patterns of informal ex-

change, may play a role in shaping nursing-home use (Institute of Medicine 1981, 81).

Living arrangements of the elderly may also affect their need for nursing-home care. Because blacks living in the community have far higher rates of functional impairment and vulnerability, they are more dependent on informal caregivers. Some evidence suggests that black families may be better able to provide such support. White elderly are significantly more likely than blacks to migrate out of state, thus cutting themselves off from extended family supports (Watkins 1989). Middle-aged black women, for example, are twice as likely as middle-aged white women to spend some time in extended-family households (Beck and Beck 1989). Other researchers have noted that friendship and kin networks appear to grow as the black elderly age, serving as a rich and important resource critical to their living independently of institutional care (Gibson and Jackson 1987). However, researchers have generally reported either inconclusive or modest differences in the amount of informal and family support available to black and white elderly (George 1988; Taylor 1988).

Another discrepancy is that the pattern of low black use rates of nursing homes is not uniform across the country (Institute of Medicine 1981, 91). For example, in the 1976 state data analyzed by the Institute, elderly blacks represented 18.7 percent of the elderly poor population in Delaware, with nonwhites making up 76 percent of the Medicaid beneficiaries in skilled nursing homes. In contrast, blacks in Alabama represented 37 percent of the elderly poverty population, but only 19.8 percent of the Medicaid beneficiaries in skilled nursing homes (Institute of Medicine 1981, 92).

A more recent analysis of overall black use of nursing homes in the Detroit metropolitan area, for example, showed that the black elderly represent a somewhat *higher* percentage of nursing-home residents than their proportion of the overall population of the area (Douglas et al. 1988). This higher distribution of black elderly in Detroit nursing homes may have resulted from the conversion of a number of black physician-owned private hospitals to predominantly black nursing homes in the 1950s and 1960s (P. Cornely, personal communication, July 28, 1990). The Institute of Medicine further notes that the theory of a distinctive set of values and family supports among blacks that reduces the need for institutional care is undermined by the disproportionate representation of blacks in state psychiatric and chronic-care

facilities (Institute of Medicine 1981, 87). All of these findings suggest that differences in access rather than ethnic social preferences account for most of the variations in use rates.

The third alternative explanation, differences in geographic and economic access to long-term care, is not really an alternative explanation at all. In a narrow legal sense, the courts over the last decade have moved from an "effect" to an "intent" standard of proof of discrimination, which is far more difficult to demonstrate (Jaynes and Williams 1989, 224-25). However, from a population ecology perspective, the conscious "intent" or choice of an individual facility to discriminate plays an insignificant role.

The "effect" of discrimination is a consequence of the choices blacks face in the larger environment when they need nursing-home care. As noted in the Institute of Medicine's review, nursing-home beds are in shorter supply in states with a higher proportion of blacks in the population (Institute of Medicine 1981, 88). At a state level, in Pennsylvania for example, the health department's data on nursing-home beds by county show strikingly higher bed population ratios in counties with a higher proportion of whites.

The effect of these patterns of discrimination in geographic access and the economic barriers that help create them, while exacerbating their consequences, is racial discrimination in access. As a result, a large proportion of the Medicaid dollars for nursing-home care, intended to provide access to the poor without regard to race, actually provides a catastrophic long-term-care insurance benefit to the white middle class.

Racial Integration. This analysis applies the most commonly used approach to measuring segregation, the Index of Dissimilarity (White 1986). An index of 0 suggests that blacks and whites are distributed across facilities proportional to their numbers. An index of 1 would show no overlap of the races. The value of the index is equivalent to the proportion of members of one race that one would need to move to obtain an even distribution across all facilities. Table 2 summarizes this index for hospitals and nursing homes in the city of Philadelphia and for the nation as a whole, using estimates extracted from the 1985 National Hospital Discharge and National Nursing Home surveys. In Philadelphia the index for hospitals was .340 and for nursing homes, .691. Similarly, the estimate of the national index for hospitals was .610 and for nursing homes .864. As a point of reference, this index of dissimilarity for residential segregation for Philadelphia was .788 and the

TABLE 2
 Segregation Index (Index of Dissimilarity) for Hospitals,
 Nursing Homes, and Residence

	Philadelphia	United States
Hospitals	.334	.610
Nursing homes	.691	.864
SMSA ^a	.788	.693

Sources: The Philadelphia hospital index was computed from fiscal year 1985 Hill-Burton reports. The Philadelphia nursing-home index was computed from fiscal year 1987 Title VI: Reports of the Pennsylvania Department of Health. National nursing-home and hospital indices were derived from unpublished data from the 1985 National Hospital and National Nursing Home surveys. Both surveys are two-stage national probability samples. The sample of patients within a facility was used to provide an unbiased estimate of its racial composition. These estimates of the racial composition of sampled facilities were then adjusted by their sampling weights to derive the overall distribution of black and white patients across facilities of varying racial composition. The national nursing-homes survey consisted of 1,054 facilities with a sample, in all but 22 facilities, of 5 residents from each facility. Information on race was obtained from interviews and is complete. The hospital sample consisted of 414 facilities and a larger sample of discharges from each facility. Information on race was abstracted from medical records. Twelve of the sampled hospitals were excluded from the analysis because race was not coded. The figures for residential segregation are from Massey and Denton (1989) and are based on the 1980 Census. The residential index for the United States is the average value for 60 standard metropolitan statistical areas.

^a Standard metropolitan statistical area: residential.

average for 60 major metropolitan areas in the United States was .693 (Massey and Denton 1989, 378-79).

At least in part, these measures of facility segregation reflect patterns of residential and geographic racial segregation. Still, such geographic and residential segregation cannot account for the substantial differences in the index for hospitals compared with nursing homes. In Philadelphia, for example, nursing-home segregation was only slightly less than residential segregation, but for hospitals the index was less than half the value for residential segregation.

Although these national measures of segregation oversimplify a complex problem, they also suggest that we have not moved very far toward an integrated society. The numbers suggest we have gone only about 14 percent of the distance in long-term care, 31 percent of the distance in housing, and 39 percent of the distance in hospital care. Economics, demographics, and more subtle patterns of discrimination

continue to reinforce multiple forms of segregation, including the segregation that exists in all forms of health services.

Discussion

This review aims to be useful to two audiences. First, it is directed to the audience primarily interested in the dynamics of organizational behavior. Second, it is aimed at the broader audience concerned with more general policy issues.

As for the first audience, I hope it will stimulate more ambitious applications of theories. Most applications of population ecology have been limited to small and socially insignificant clusters of organizations. This perspective provides an important antidote to the general economic models applied to complex social problems.

For the broader-policy audience, this review has direct implications for current discussions of health policy and management. Four of the most obvious, related implications will be briefly summarized here.

1. *Ecological determinism tends to be underestimated and structural inertia overestimated.* Most facilities adapt quickly to clear shifts in their ecological niche. The recent rapid decline in average length of hospital stay and the growth in ambulatory procedures owing to the introduction of Diagnostically Related Group (DRG) prospective payment in Medicare and many state Medicaid programs reflect this responsiveness. Policy makers should not have been as surprised as they were. Changes in the ecological niche of providers are powerful producers of organizational change. How patients and a community pay for care is a critical feature of the ecological niche of providers, influencing their willingness to eliminate racial barriers aggressively.

As the case of hospitals and nursing homes illustrates, care that was part of a universal entitlement, rather than personal out-of-pocket expenditure, faced less resistance to integration efforts. For example, in North Carolina two fully integrated facilities quietly operated undisturbed before the 1960s, both providing a form of general entitlement. One was a polio hospital constructed after a massive epidemic in Greensboro during 1947 and 1948. The National Polio Foundation, which had provided most of the funds, insisted on integration and it met with little local resistance (Chafe 1980, 39). However, segregated care reappeared after the crisis had subsided and the funds and influ-

ence of the National Polio Foundation on the facility waned. The other example was the Veteran's Administration Hospital, which desegregated by a directive from the system's chief medical administrator in 1950 without disruption. Both of these cases, as well as the Medicare program for hospitals, illustrate the advantages of operating outside a private market in integrating services.

2. *Efforts to create the same reimbursement and market incentives for hospitals as for nursing homes will create the same consequences.* Given the persistence of these incentives, one can expect increasing problems of access for blacks to acute-care facilities and increasing segregation of acute care. The financially viable and expanding hospitals, like the larger, financially viable nursing-home chains, occupy a niche that increasingly focuses on the affluent, suburban, private-pay, and almost exclusively white market. Unlike schools, housing, and employment, the public—black or white—pays little attention to health facilities on a day-to-day basis. With the exception of the rare, dramatic instances of hospital closings, as little outcry can be expected as resources are shifted away from hospital services in black communities as when hospitals moved in the opposite direction in the 1960s.

3. *With the blurring of differences between the ecological niche of hospitals and nursing homes, nursing homes will face the same challenge to survival as a separate sector that black hospitals did in the 1960s.* Nursing homes have occupied a separate ecological niche, just as black hospitals once did. The development of a separate long-term-care sector was an artifact of the different methods of third-party payment. There is nothing logically inevitable about the organization of acute- and long-term care into two separate sectors, as it currently exists in the United States. There is far less separation in the organization of these services in other developed countries. The artificial boundaries and disincentives created by the Medicare and Medicaid programs arrested the development of community continuum of care models by hospitals that began in the 1950s in the United States (Barker 1987).

Much of the current long-term-care debate between "medical" and "social" models of care is more a struggle over organizational control than about philosophies of care. Yet, there appear to be increasingly formalized linkages between acute-care hospitals and long-term-care facilities (Bowlyow 1990). Specialized organizations, population ecology theory argues, are likely to give way to generalist organizations in increasingly complex, resource-constrained, and competitive environ-

ments (Kaluzny et al. 1987). From this perspective, one would predict the eventual elimination of a separate long-term-care sector.

4. *Facilities can help collectively shape their environment to the extent that they share a desired future with elements of their larger organizational environment.* Although this review seeks to make a convincing case for environmental determinism, it fails to support the other major premise of the population ecology perspective: structural inertia. The smooth, rapid adaptation of most facilities suggest that, although individual health facilities had limited choices, individual organizational participants were not unaffected by what was happening in the larger environment. The civil-rights movement demonstrated that the larger organizational environment was amenable to human intervention. It was changed by collective action producing an altered social, legal, and financial environment for institutions.

The alternative, and less pessimistic, ecological perspective, that of social and human ecology, may provide a better fit (Astley and Van de Ven 1983). It stresses the influence of collective purpose and choice and the interactive role of organizational participants in shaping their environment. In essence, the experience in racially integrating the nursing-home and acute-hospital sectors in the United States provides a fragmentary glimpse of what different collective choices in shaping the environment of health facilities will produce.

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