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“Let Down Your Bucket Where You Are”

The Afro-American Hospital and Black Health Care in Mississippi, 1924–1966

Under the burden of Jim Crow, how did African Americans obtain health care? For nearly 40 years the Afro-American Hospital of Yazoo City, Mississippi, was a leading health care supplier for blacks in the Mississippi Delta. It was founded in 1928 by the Afro-American Sons and Daughters, a black fraternal society, and provided a wide range of medical services. The society, which eventually had 35,000 members, was led by Thomas J. Huddleston, a prosperous black entrepreneur and advocate of Booker T. Washington's self-help philosophy. The hospital had a low death rate compared to other hospitals that served blacks in the South during the period. It ceased operation in 1966 as a fraternal entity after years of increasingly burdensome regulation, competitive pressure from government and third-party health care alternatives, and the migration of younger dues-paying blacks to the North.

Health care for blacks in Mississippi during the early 1920s was a textbook example of second-class citizenship. Mississippi was not only the poorest state in the nation, and its black population poorer still, but whites completely monopolized the existing hospital system under conditions of rigid and unequal segregation. White hospitals either did not admit blacks at all or gave vastly inferior treatment (Harrell 1973: 554–59). In 1924 Thomas J. Huddleston, a prosperous black entrepreneur from Yazoo City, Mississippi, decided to do something about this. He proposed a revolutionary plan to build the first black-owned hospital in Mississippi (*Afro-American Courier*

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1934c). To accomplish this goal, Huddleston established the Afro-American Sons and Daughters (AASD), a fraternal society.

In choosing this method, Huddleston was following a well-trodden path. The black fraternal tradition was older than the United States itself. In 1775 Prince Hall, who was born in the West Indies, formed an all-black lodge of Masons in Boston after he was spurned by the white organization. It developed into the Prince Hall Masons, the first national fraternal order for blacks (Muraskin 1975: 31; Curry 1981: 208–91). By the end of the nineteenth century, blacks flocked to such organizations as the Grand United Order of Odd Fellows, the Colored Knights of Pythias, and the Grand United Order of True Reformers (Brooks 1971 [1902]: 226–27; Fahey 1994: 13–19; Skocpol and Oser 2004: 380–81; Trotter 2004: 356). Standard features of these organizations included networks of local lodges, rituals such as secret grips and regalia, and burial insurance. The Independent Order of St. Luke and a few others established banks and newspapers (Brown 1989: 610–33). In addition, blacks throughout the South organized countless local societies. For example, 400 such organizations were founded in Richmond during the 1870s (Hunter 1997: 71–73).

Fraternal societies had long taken an interest in health care. During the nineteenth century, for example, many organizations, such as the Grand United Order of Odd Fellows, gave weekly stipends to compensate members for lost working days (Brooks 1971 [1902]: 91, 101; Curry 1981: 211–12). A more ambitious method of health care was lodge practice. It involved a contract under which a general medical practitioner provided basic care in exchange for a fee determined by the size of the membership. At the turn of the century, lodge practice existed in such diverse organizations as the all-white Loyal Order of Moose and the Jewish *landsmanshaftn* (associations of immigrants from the same hometown). It was also well established among blacks in New Orleans, who by the 1920s belonged to over 200 groups offering a doctor's care (Walker 1937: 18–27; Jacobs 1988: 21–23). By the 1910s a handful of black organizations in the Deep South were considering the more ambitious goal of direct hospital care.

If anyone could accomplish the feat of building the first such hospital in Mississippi, it was Huddleston. He had ample talent, energy, and wealth as well as familiarity with earlier precedents in fraternal hospitalization. Born in 1877 in Humphreys County, he inherited extensive acreage from his father. Soon after attending Rust College in Holly Springs, Mississippi, he taught

school in Yazoo City, located on the southern tip of the Delta area, where most blacks in Mississippi lived (Huddleston 1980) (see figure 1). Huddleston dabbled in business investments such as real estate and also worked as a building contractor. Local blacks gave him the nickname Cousin Tom for the loans he provided to help them purchase homes or to ward off creditors (*ibid.*; *Century Voice* 1942b).

Huddleston learned the ropes of fraternalism in the 1910s as an official of the Woodmen of Union, based in Yazoo City. The direct influence of John L. Webb, the grand custodian of the organization, shaped his ideas and sharpened his leadership skills. Webb, like Huddleston, was a building contractor and had real estate investments (Griggs 1926: 17–21). Around 1919 Webb moved the headquarters of the order to Hot Springs, Arkansas (Thomas 1926: 384–85). Huddleston stayed behind in Yazoo City but remained actively involved in the organization. Under Webb's leadership, the Woodmen purchased a four-story building in Hot Springs, valued at \$500,000, which occupied an entire city block. By 1923 it housed a 100-bed hospital and a 56-room hotel (Polk 1923: 41; *Arkansas Gazette* 1990). The Woodmen of Union Hospital was a great success; within a few years the membership had mushroomed from fewer than 100 to over 45,000 (Thomas 1926: 384–85).

Drawing on this experience, Huddleston began plans to establish a fraternal hospital in his home state of Mississippi. He recruited his friend Lloyd T. Miller of Yazoo City to be a cofounder of the AASD as the sponsoring organization. Miller was born in 1874 in Natchez, Mississippi, where his father owned a horse and mule transportation company. He graduated from Meharry Medical College in Nashville and settled in Yazoo City in 1893. Soon he was performing about 30 operations per month. His practice expanded so rapidly that in 1907 he opened an infirmary to give patients a place to stay during recovery. With 18 beds, it was the largest and best-equipped medical facility for blacks in the state. He also owned a drugstore (*Ebony* 1950). Huddleston focused on recruiting members, while Miller cared for them in his infirmary. Huddleston knew that Miller's experience, prestige, and entrepreneurial skills were essential for the plan to have a fighting chance. Their partnership lasted until Miller's death nearly 30 years later (Huddleston 1980).

Nobody doubted the need for such a hospital. Blacks in the area had meager health care options. While six state hospitals offered them limited services in 1929, all were in southern Mississippi rather than the Delta. Rules often

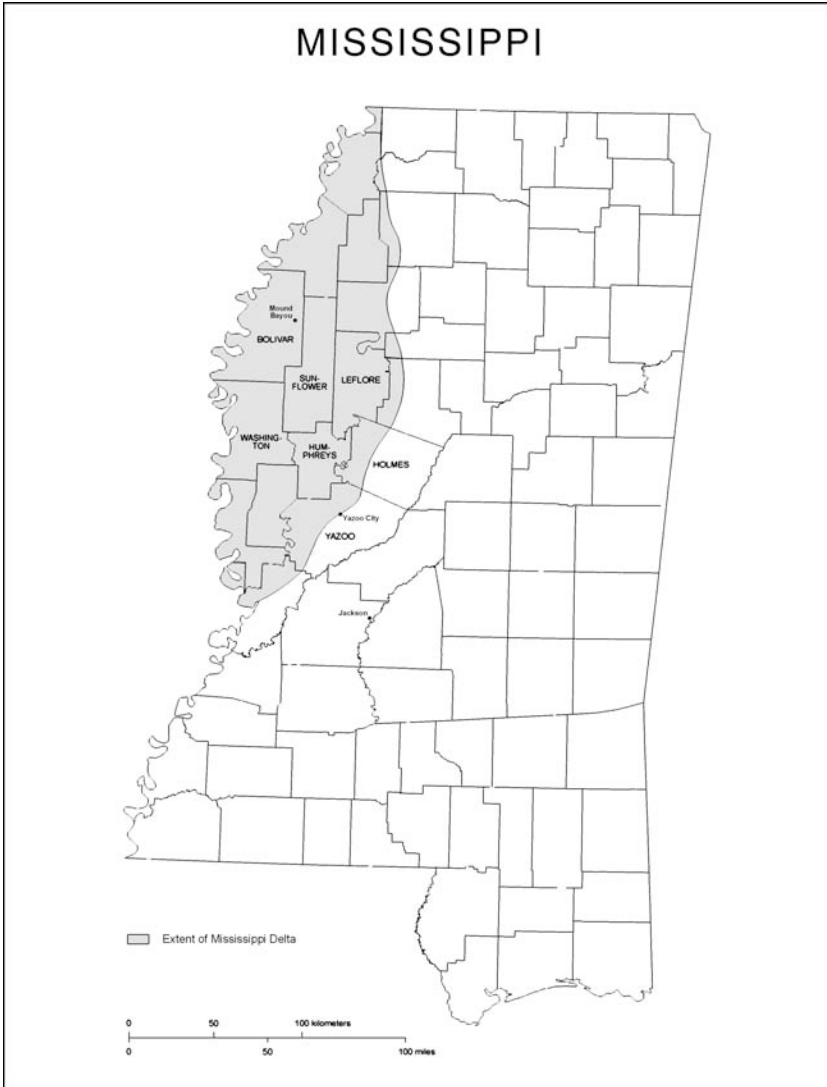


Figure 1 Map of the Delta area of Mississippi

required patients to bring their own utensils, toothbrushes, and linen and to hire a black nurse if one was not on staff (Walker 1929; Beito 2000: 183).

Before Huddleston and Miller could launch the hospital, a daunting hurdle lay ahead. The state required that any new fraternal organization post a bond of \$1,000. Miller and Huddleston could not give contributors any guarantee, only the prospect of a hospital. At some risk, Huddleston promised a refund if he failed to raise the necessary amount in a year's time. His powers of persuasion made all the difference, and he successfully paid off the bond by recruiting over 1,000 members. In 1927 a general membership meeting of the AASD imposed a per capita "tax" of 50 cents to pay for the hospital (*Afro-American Courier* 1927g). The pressure was on as never before to find new members. Huddleston and other leaders of the order traveled throughout the state to organize lodges. They raised more than \$20,000, and membership had grown to 16,000 by 1927, up from nothing in 1924 (*Afro-American Courier* 1927a). In a 60-day period in 1928, 40 new lodges were added to the rolls (*Afro-American Courier* 1927f).

AASD recruiters stressed their dedication to organizational efficiency, self-help, and business ownership. During the initial recruiting campaign, Learah Hill, the recording secretary of the Greenville lodge, expressed this message in a poem for the *Afro-American Courier* (1927d), the newsletter of the AASD:

Afro-American is worth being in
Members don't have to die to win.
It will help you while you live,
And will surely protection give.

It pays more than any concern,
Helps you a livelihood to earn.
It has the very cheapest rates,
And I like it because it educates.

If you are taken with appendix or tumor,
Don't be misled by any false rumor.
If your doctor says operation,
Go to the Yazoo Hospital without hesitation.

There you will find the worthy Dr. Miller,
Ready to administer, and is real particular.

Assisting him are nurses of skill and beauty:
They'll send you back home all ready for duty.

When the Afro-Americans were in trouble
They turned to T. J. Huddleston.
A successful, thrifty building contractor
Who stands out now as a race benefactor.

Like Webb of the Woodmen of Union, Huddleston was a firm believer in the self-help, bottom-up ideas of Booker T. Washington (Griggs 1926: 11–12). The masthead of the *Courier* featured the Wizard of Tuskegee's admonition to "let down your bucket where you are." An editorial elaborated that "our slogan is foresight, faith and endurance. . . . Push, pull. The height to which we are to attain is before us" (*Afro-American Courier* 1926). In another article Zanzye H. A. Hill, an attorney with the AASD, urged blacks "to realize the well-accepted business axiom that to start at the bottom rung of the ladder more definitely fetters and assures the way for the ability to do Big Business in a commanding way, when the top has been reached" (*Afro-American Courier* 1934b). Similarly, the publications of the AASD pledged to foster "race consciousness, along the line of mutual cooperation" and "awaken every member of the Negro family to consciousness of social, moral and financial uplift" (*Afro-American Courier* 1927b). Huddleston never tired of reminding anyone who would listen of his intention to better the financial condition of the "sons and daughters of Ham" (Huddleston 1980).

AASD leaders repeatedly emphasized the "Christian nature" of the organization, no small matter in a state where the rural church was the center of black social life (*Afro-American Courier* 1927c). Unfortunately, no copy of one of its rituals could be found, but according to a description it centered on the story of Joseph, who rose from the status of slave to the right-hand man of the pharaoh. John A. Jackson, grand lecturer of the AASD, declared that the Bible was the order's "guide and light" (*ibid.*). Like most fraternal societies, black and white, the AASD pledged to avoid "the spread of political propaganda" (*Afro-American Courier* 1927b).

While the primary inducement for blacks to join was hospitalization, the AASD's fraternal format also offered members more intangible benefits. The lodges and state organization were leading sources of entertainment and sociability. They sponsored contests, festivals, banquets, and candle-light parades on almost a regular basis (Bardfield and Harris 1929; *Afro-*

American Courier 1938b, 1939a). Women members mobilized through auxiliaries to raise funds for various projects, such as linen showers, to improve the hospital (*Afro-American Courier* 1928b, 1957). At a time when 90 percent of adult blacks in Mississippi were disfranchised, the AASD was a rare outlet for learning the arts of self-government, leadership, and parliamentary procedure.

The opening of the AASD hospital in 1928 represented a major milestone in the history of black accomplishment in Mississippi. Huddleston went all out to ensure a successful dedication ceremony, using the occasion to acknowledge his debt to the Woodmen for showing the way. The main speaker was Sutton E. Griggs, Webb's biographer. The highlight of the dedication ceremony was an "auto parade" from the courthouse to the hospital. A band triumphantly played the hymn "No More" as an official publicly read the deed. Huddleston carefully cultivated white goodwill by inviting a representative of the chamber of commerce to be present. He also opened the facilities for inspection by "our white friends" and solicited their financial support (*Afro-American Courier* 1928a).

Despite the great fanfare, the hospital, which was valued at about \$50,000, was a modest enterprise. The only two doctors were Miller and his assistant, Robert E. Fullilove. Over time, fund-raising and membership drives led to incremental improvements. The next decade brought an annex, X-rays, 2 operating rooms, and about 100 beds. Membership rose to 35,000 (*Afro-American Courier* 1935a, 1937d, 1939c; Walwyn 1980). With the possible exception of churches, the AASD had become probably the largest black voluntary association in the state. In the first 15 years of operation, over 14,000 patients received treatment (*Afro-American Courier* 1944).

Membership dues were low by any standard. All initiates purchased a life or burial insurance policy that also guaranteed free hospitalization. In this respect, the AASD followed a general fraternal pattern of piggybacking hospital care on top of life insurance. A policy valued at \$500 cost \$1.25 per month plus a joining fee of \$2.00, while one valued at \$125 cost 50 cents per month plus a joining fee of 75 cents. The more expensive policies also guaranteed cash sick benefits of between \$1.48 and \$2.48 per week. Parents secured hospitalization for their children by enrolling them in the juvenile division. Each policy for ages 3 to 12 was worth \$100 and cost 25 cents per month plus a joining fee of 25 cents (*Afro-American Courier* 1935b). The "juvenile mothers" supervised special units for children in each lodge and

organized monthly meetings. The children, in turn, elected their own officers (*Afro-American Courier* 1927e). Few cooperative health plans in the United States during the 1930s approximated the AASD's low rates. For example, the better known Ross-Loos plan in California charged an average of \$2.69 per month for hospitalization (Starr 1982: 301). In contrast to the AASD, this fee did not include cash death benefits.

While the rate differential can be explained partly by Mississippi's lower cost of living, the AASD also found effective ways to minimize costs. State hospital regulations, which were almost nonexistent for black hospitals, gave the AASD the necessary flexibility to do so. Training for most nurses and other staff was on the job by the doctors and included instruction in such techniques as the fine points of dispensing ether as anesthesia (*Afro-American Courier* 1935c). While doctors received low salaries, they were able to compensate for them somewhat by charging for extras and maintaining private practices on the side. In a more general sense, work at the hospital aided their private practices by making them better known in the community. Extra revenue was generated for doctors and the AASD alike from nonmembers who paid out of pocket to use the facilities (Huddleston 1980; Lindsey 1980).

The hospital's reach extended far beyond Yazoo County (see figure 1). The addresses of 366 patients from May 1936 to November 1941 show that they came from 33 counties in Mississippi and two other states (Louisiana and Arkansas). A majority lived in the five Delta counties of Sunflower (19.1 percent), Washington (10.5 percent), Yazoo (10.0 percent), Bolivar (9.1 percent), and Holmes (8.9 percent) (*Afro-American Courier* 1936a, 1936b, 1937b, 1937c, 1940, 1941b). Each of these counties was at least 67 percent black (U.S. Bureau of the Census 1932: 1282–87). The top two contributors of patients, Sunflower and Washington to the north, did not even border on Yazoo County, though they were within 60 miles of it. The wide geographic dispersal was testimony to the popularity of the hospital as well as the lack of alternatives. The doctors in members' home communities often acted as gatekeepers of whether a case merited the trip to Yazoo City (Huddleston 1980).

The most detailed source of information about the nature of the health care the hospital provided is a register of over 2,300 patients from 1931 to 1935 at the Mississippi Department of Archives and History (AASD Hospital 1931–35). It notes diagnoses, deaths, lengths of stay, and occupations. Names were blacked out for privacy reasons, so it is impossible to determine the number of repeat patients. Patient records show that an overwhelming 76

percent were women. It is likely, although not certain, that women were also a majority of members. This was certainly the case with the AASD's most important competitor in the Delta, the Knights and Daughters of Tabor, which had a female majority of nearly two to one (International Order of Twelve Knights and Daughters of Tabor c. 1942: 7–8). One reason for the high numbers of women was that both societies had close ties with the church, a center of female influence.

Farming was the most common occupation of patients (40 percent of the total). Unfortunately, the register does not specify the breakdown among owners, sharecroppers, and tenants. Housewife (23 percent) was second on the list. At least 15 percent, probably much more, of the patients worked in domestic service or other forms of unskilled labor. While most patients were on the lower economic rungs, representatives of the black elite were also in evidence and included a smattering of entrepreneurs, ministers, and most especially teachers (15 percent). Not surprisingly, because the newly organized AASD had discouraged recruiting the elderly as initiates, the median age of patients was a relatively young 28 (AASD Hospital 1931–35).

The diagnoses as recorded in the register show nearly every imaginable health problem or condition, including broken legs, gunshot wounds, and venereal disease, but the top four were appendicitis (15 percent), tonsillitis (11 percent), tumors (unspecified) (7 percent), and fibroid tumors (5 percent). Not surprisingly, given the number of female patients, the register listed a wide variety of gynecological conditions or treatments, some vaguely described. These included salinities (inflammation of the fallopian tubes), curettage (removal of diseased tissue from the uterus), overbites (complaints related to the ovaries), breast cancer, and “female trouble” (*ibid.*).

Relatively few obstetrical cases appeared and even fewer births (less than 1 percent) (*ibid.*). An AASD official later commented that most women still preferred to rely on midwives. One deterrent to using the hospital rather than the neighborhood midwife was geographic distance. The trip from Cleveland, a principal town for blacks in the Delta in Bolivar County, to Yazoo City was over 60 miles, and an automobile was often not available (see figure 1). Also pregnant women, like other patients, may have regarded the hospital primarily as a place to go for major health issues, a category that, in their view, might not include the birth of a child. The midwife was so ubiquitous among blacks, delivering about 90 percent of all infants, that even those with access to a doctor had little incentive to break the old pattern (McBride 2002: 138).

While the record does not indicate methods of treatment, patients apparently were not likely to see the hospital as a place to go for diseases that required drugs or were regarded as incurable. For example, while malaria was the most prevalent disease reported in Mississippi and blacks were more likely to be sufferers than were whites, it generally constituted only 2 percent of hospitalization cases (U.S. Public Health Service 1923a: 570, 1923b: 1327, 1924a: 718, 1924b: 1286, 1924c: 1918; Humphreys 2001: 62). Rather than visit a hospital, many blacks preferred traditional remedies (McBride 2002: 29–30). Even fewer patients sought treatment for tuberculosis and syphilis, which also brought social stigma, in great part because effective and inexpensive treatments such as penicillin were not yet available (*ibid.*: 201). Evidence of sickle-cell anemia, sometimes described as “bad blood,” or anemia of any kind is almost entirely absent from the patient register (Wailoo 1997: 138–40).

Despite the emphasis on operations and treating accidents, doctors and AASD leaders, like their counterparts in other fraternal societies, black or white, repeatedly promoted the hospital as a source for preventive care (Beito 2000: 12–21). In a lengthy front-page article for the *Courier*, Zanzye H. A. Hill warned against waiting “until the ember had begun to die out by progressing disease and ignorance as its treatment. That is just what hospitals are to prevent. Hospital treatment aims to supervise and to prevent as well as to cure” (*Afro-American Courier* 1934a). The AASD’s annual Hospital Celebration Day showcased the importance of prevention by featuring an examination clinic, which was also a means to advertise for new members. The doctors at these annual events gave free examinations but charged for medicine. An article in the *Courier* recommended that readers set aside money for “health maintenance” as a regular item of household budgets and visit the free clinic as a way to “nip the disease in the bud” (*Afro-American Courier* 1939b).

It is difficult to assess the quality of care in the hospital. Most firsthand accounts are positive, but virtually all come from people who had an emotional stake, such as patients who volunteered testimonials for the *Courier* and doctors, staff, and fraternal officials who later gave interviews (Huddleston 1980; Lindsey 1980; Walwyn 1980). The death rate, as shown by the patient register, is the most specific available measure of quality. While no comparative data exist for other hospitals in Mississippi, they do for South Carolina. According to the Duke Endowment, more than 13 percent of black patients in South Carolina between 1931 and 1935 died while in the hospital (Duke Endowment 1932, 1933, 1934, 1935, 1936). The Afro-American Hospital, by

comparison, showed a much lower death rate during these years of just over 4 percent (AASD Hospital 1931–35).

For more than a decade, the Afro-American Hospital did not have to bother with serious competitors. In 1938, however, this began to change. The annual meeting of the Mississippi jurisdiction of the International Order of Twelve Knights and Daughters of Tabor voted to establish a fraternal hospital in the all-black town of Mound Bayou, about 70 miles north of Yazoo City (see figure 1). Unlike the AASD, the Knights and Daughters (founded in 1872 in Ohio) had a long fraternal track record and lodges throughout the United States with the standard repertoire of fraternal services, including cash sick and death benefits. The main mover behind the hospital idea was Perry M. Smith of Mound Bayou, who, like Huddleston, was a schoolteacher and had belonged to the Woodmen of Union. When Smith took charge of the Mississippi jurisdiction of the Knights and Daughters of Tabor in the late 1920s, the organization was at a low ebb (Beito 2000: 182–84).

A turning point in Smith's thinking was a personal experience. He had brought his child to a white-owned hospital, entered through the back door, waited in vain for a doctor, and eventually left. According to Smith's sister-in-law, he then "carried the patient to the AASD Hospital in Yazoo City, Mississippi. There they entered the front door" and were "treated with courtesy and respect. That day, he decided to organize Tabor [the Taborian Hospital] in Mound Bayou." Smith never failed to give credit to the AASD for providing the inspiration (Coleman 1995: 2; Beito 2000: 183–84).

Huddleston and other AASD leaders responded in kind. In public pronouncements, they gave unqualified and enthusiastic praise to Smith's plan. The *Courier* called the Knights and Daughters "one of the WONDERS of the world" and informed readers how they could join this "wonderful organization" (*Afro-American Courier* 1938a). As guest of honor at the dedication ceremony for the Taborian Hospital in Mound Bayou, Huddleston "spell bounded the audience with real facts and figures of the successful operation of an all-Negro owned and operated hospital" (*Taborian Star* 1942). Later the *Century Voice* (1943), also published by Huddleston, carried advertisements for the Knights and Daughters of Tabor.

This abundant display of mutual goodwill, especially on Huddleston's part, may seem counterintuitive for two competitors who drew on many of the same markets. Two of the five counties that contributed the most patients to the Afro-American Hospital adjoined Bolivar County, where

Mound Bayou was located (see figure 1). Bolivar County itself was the Afro-American Hospital's fourth-largest source of patients. Nevertheless, Huddleston and Smith had good reason to favor cooperation and friendly competition rather than antagonism. Even before Smith embarked on his campaign, Huddleston had estimated that to be successful in the long term, any hospital required a critical mass of 5,000 subscribers within 50 miles of it. At the time, he suggested that the AASD might respond to this dilemma by building a second hospital (*Afro-American Courier* 1937a). This was a Herculean task, however, and Huddleston sensibly chose to embrace Smith's alternative when it came along. Perhaps, too, he thought that nearby growing urban areas such as Jackson offered new frontiers for members.

At least initially, Huddleston appears to have gambled wisely in his policy of conciliation. The AASD's membership growth leveled off at about 35,000 during the first decade of the Taborian Hospital's existence. The membership of the Knights and Daughters, by contrast, jumped to nearly 50,000 by 1945, but it catered primarily to a local market. From 1942 to 1946, 86 percent of the Taborian Hospital's patients hailed from the adjoining counties of Bolivar, Sunflower, Coahoma, and Washington. For the time being, at least, there were enough potential members and patients to go around (*Ebony* 1950).

Huddleston also compensated for any losses from competition by dreaming up new ways to make profits. In 1932 he purchased the Century Burial Association, a commercial enterprise that sold small burial policies, or industrial insurance, that did not require medical examinations. Under Huddleston, the membership rose from only a few hundred to about 100,000 in 1942 (*Century Voice* 1942c). That year the Century had a casket factory and 15 funeral homes and employed 500 workers (*Century Voice* 1942a). While technically separate, the Century and the AASD had a close and complementary relationship. For example, policyholders of the Century received free ambulance service, which, of course, might transport them to the Afro-American Hospital (*Afro-American Courier* 1941a; Huddleston 1980).

By the 1950s, however, the first signs of decline of the AASD and the Afro-American Hospital were apparent. The reasons were similar to those that led to the downfall of the Knights and Daughters of Tabor and the Taborian Hospital. Increased regulatory burdens imposed by the state beginning in the late 1950s played a key role, raising costs and putting upward pressure on fees and services. Before this time, the state government had

taken a relatively hands-off approach. The political and medical establishment had operated under the theory that the existence of black hospitals freed white taxpayers and white doctors from additional charity-care obligations (Walwyn 1980; Beito 2000: 195).

Another important catalyst to change was the Hill-Burton Hospital Construction Act of 1946, which offered states grants to build and modernize hospitals, outpatient clinics, and public health centers. Two provisions cut deeply into the patient base of the Afro-American Hospital and other black fraternal hospitals that catered to the poor. The act required that hospitals devote a portion of the funds to indigent care and stipulated that all services be offered “without discrimination on account of race, creed or color.” Of course, there were gaping loopholes, and enforcement was incomplete. For example, the act allowed southern states to maintain hospital segregation as long as they gave blacks care “of like quality.” Even so, these grants slowly helped to make both free and paid hospital care more available to blacks, albeit under conditions of segregation (Walwyn 1980; Starr 1982: 348–51; Beardsley 1987: 176–78).

Even more directly, the Hill-Burton Act hindered the ability of the Afro-American Hospital to make necessary capital improvements to compete successfully. It did not receive a cent of federal funds, while other hospitals in the area reaped a windfall. Overall, health facilities in Yazoo, Washington, Bolivar, Sunflower, and Holmes counties obtained \$4.8 million from the federal government from 1947 to 1969. The state also allocated funds enabling nonfraternal hospitals to upgrade their equipment and add 586 beds. A small but rising number of the beds were for blacks in segregated hospitals (U.S. Department of Health, Education, and Welfare 1970: 150–58).

This trend created a dilemma for AASD leaders. As more beds opened up during the late 1950s, they could no longer claim credibly that their hospital was the only source of care for indigents. Thus they were less able to call on white planters and doctors to shield them from regulators. The state hospital commission began to crack down, imposing ever more burdensome requirements on such details as fireproofing and space requirements for patients and beds. This meant that black fraternal hospitals, always marginal enterprises, had an even steeper uphill battle to keep pace. Cyril A. Walwyn (1980), the last chief surgeon of the Afro-American Hospital, recalled that the hospital commissioner of Mississippi had confided to him that he had “permitted us

to operate without [the regulatory] qualifications for years because there was nothing else — there was nowhere else to go and we were doing a good job. . . . your record is as good as *any* hospital in the state, he told me. But you don't meet the qualifications.”

Heavy-handed regulation was also a factor in the decline of at least three other fraternal hospitals in the Deep South, the Taborian Hospital and the Friendship Clinic, both in Mound Bayou, and the United Friends Hospital in Little Rock, Arkansas. While the Mississippi Commission for Hospital Care's files on the Afro-American Hospital do not survive, those of the Taborian Hospital and the Friendship Clinic do. Beginning around 1960, they show a major shift away from the previous policy of regulatory *laissez-faire*. The commission increasingly found the hospital guilty of such infractions as inadequate storage and bed space, failure to install doors that could swing in either direction or fire-resistant walls that could be scrubbed more easily, and excessive reliance on uncertified personnel (Walls 1986: 4–8; Barnes 1995; Beito 2000: 195–97).

Another long-term reason for the decline of the AASD and its hospital was the rise of third-party payment systems for health insurance. During the 1940s employers began to provide care through private insurers such as Blue Cross and Blue Shield. While the vast majority of AASD members did not obtain this private insurance, a small but growing segment from the middle class would have been eligible. By the early 1960s the federal government had already joined the ranks of third-party insurers by providing health care for the indigent, capping this off with the federal Medicare and Medicaid programs. Because doctors and hospitals shifted many of their expenses to government and insurance companies, health care costs rose (Walwyn 1980; Gamble 1995: 193–94).

This trend also encouraged a competitive race to add more costly medical technology. With increased automobile ownership, members saw little reason to pay dues for a hospital in Yazoo City when they could secure subsidized “high-tech” health care, either through their jobs or through the taxpayer, closer to home. The breakdown of Jim Crow hastened but did not cause this process. Because previously all-white hospitals and clinics desegregated, blacks no longer had the same incentives to support black-owned alternatives (Gamble 1995: 192–93; Beito 2000: 196–97).

Meanwhile, the mass flight of blacks to the North in the post-World

War II period cut deeply into the rank and file. Because many migrants were young, their departure left behind a dwindling and aging membership. The elderly, of course, were more likely to increase costs by heavy use of the hospital. The AASD did not adapt effectively to changed conditions. Although the old rates were no longer realistic, members fought proposals to raise them. Some patients increasingly took advantage by demanding free service. The leadership was overly indulgent because of a need to counteract the hemorrhaging of the membership rolls (Huddleston 1980; Walwyn 1980). Their efforts were in vain. By 1963 the ranks of the AASD had fallen to only 6,000, down from 32,000 in 1950 (Mississippi Insurance Department 1963: 404). Members in outlying areas had more motivation than ever to shift to health care facilities closer to home. In contrast to the 1930s, a majority of 324 hospital patients shown in two lists from 1962 and 1963 in the *Afro-American Courier* lived in Yazoo County.

The end of the Afro-American Hospital as a fraternal entity finally came in 1966, when Yazoo County took it over after years of decline. Harried by aggressive state regulators on one side and creditors on the other, the AASD fell into receivership. A few years later the county closed it down for good (Mississippi Hospital Licensing Agency 1966; Walwyn 1980). It represented part of a more general trend. Dogged by similar regulatory and demographic pressures, the Taborian Hospital and the Friendship Clinic ceased operation as fraternal entities in 1967, while the United Friends Hospital lingered until 1975 (Walls 1986: 4–8; Barnes 1995; Beito 2000: 195–97).

For nearly 40 years the Afro-American Hospital gave health care to thousands of blacks throughout Mississippi, standing out as a powerful illustration of how ordinary people could create social services through mutual cooperation. Operating within a context of financial pressure and poverty, the Afro-American Hospital turned in a credible record of quality care at affordable rates. In addition, the AASD nurtured black leadership that later found expression in business, civil rights, and politics. Huddleston's grandsons, for example, include Henry Espy, the mayor of Clarksdale; businessman Thomas H. Espy; and former U.S. secretary of agriculture Mike Espy (*Clarion-Ledger* 2005). Despite its accomplishments, the Afro-American Hospital succumbed to adverse health care, social, and political trends.

Note

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