Minimum Wages and Racial Infant Health Inequality: Evidence from the Fair Labor Standards Act of 1966 *

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Abstract

The Fair Labor Standards Act of 1966 increased the federal minimum wage in several industries previously excluded from federal minimum wage legislation. As a result of this act, the minimum wage increased to 1 USD in 1967 for workers in several previously excluded industries. These changes disproportionately affected Black workers, substantially narrowing the racial wage gap over a period of just a few years (Derenoncourt and Montialoux, 2021). In this paper, I use a difference-in-differences-in-differences approach to evaluate the effect of narrowing the racial wage gap on the racial infant mortality gap. I estimate the model at the county level, exploiting variation in industry employment shares as measured in the early 1960s. Intuitively, counties that pre-reform had higher shares of employment in industries affected by the Fair Labor Standards Act of 1966 in this sense were more treated by the reform and experienced greater narrowing of the racial wage gap. Using employment shares from the 1960 Census, an increase in covered employment by one percentage point reduces the infant mortality gap by about 0.16 deaths per 1,000 births (or 1.2% of the mean racial infant mortality gap).

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1 Introduction

After years of increasing disparities between birth outcomes for white and Black Americans, the racial gap in infant mortality decreased substantially between the mid 1960s and the early 1970s (Chay and Greenstone, 2000). In 1965, a full four percent of Black infants in the United States died within one year of birth (Chay and Greenstone, 2000). By 1971, the mortality rate for Black infants had dropped to 2.8 percent, a much steeper decline than the corresponding decline in infant mortality for white infants (Chay and Greenstone, 2000). In the decades that followed, Black infant mortality would only fall another 1.7 percentage points to 1.1 percent in 2018 (CDC). Almond, Clay, and Greenstone (2006) show that the desegregation of hospitals stemming from the 1964 Civil Rights Act can explain a considerable portion of this decline between 1965 and 1971 in the South, but other factors are needed to explain the gains in other parts of the country. In this paper, I evaluate the role of one potential factor in this decline: the rapid decrease in the racial income gap resulting from the Fair Labor Standards Act of 1966.

When the original Fair Labor Standards Act of 1938 was passed, only a subset of industries were covered under the federal minimum wage in an effort to appease Southern Democrats who opposed a more comprehensive minimum wage. The Fair Labor Standards Act of 1966 increased the federal minimum wage in several industries that were previously excluded from this federal minimum wage legislation. As a result of the Fair Labor Standards Act of 1966, the minimum wage increased to $1 USD for workers in agriculture, forestry and fishing, restaurants, hotels, laundries, and other personal services, entertainment and recreation services, nursing homes and other professional services, and hospitals (Derenoncourt and Montialoux, 2021). These changes disproportionately affected Black workers, substantially narrowing the racial wage gap over the period of just a few years (Derenoncourt and Montialoux, 2021). Derenoncourt and Montialoux (2021) do not find evidence of dis-employment effects for Black workers [1]. Given the extensive literature documenting the relationship between income and birth outcomes, one might expect this decrease in the racial wage gap to directly affect the racial gap in infant mortality

I use a difference-in-differences-in-differences approach to evaluate the effect of narrowing the racial wage gap on the infant mortality gap. I estimate the model at the county level, exploiting variation in industry employment shares as measured in the early 1960s. Counties that pre-reform had higher shares of employment in industries covered by the Fair Labor Standard Act of 1966 were more affected by the reform, providing a measure of treatment intensity. I find economically and statistically significant narrowing of the racial infant mortality gap from the minimum wage reform. To the best of my knowledge, I provide the first quasi-experimental evidence that increases to the minimum wage have narrowed the racial infant mortality in the United States, a country which still suffers from severe racial health inequality from even before birth.

2 Related Literature

This study builds on a small but growing literature estimating the relationship between minimum wage and infant health. One of the earliest estimates of a positive effect of the minimum wage on infant health comes from Strully, Rehkopf, and Xuan's 2010 study of

[1] Using a different empirical strategy, Bailey et al. (2021) do find some reduction in employment for Black men, but, as they describe in their Online Apendix, the workers who were most likely affected negatively were those already least attached to the labor market. One important difference between Derenoncourt and Montialoux (2021) and Bailey et al. (2021) is that Bailey and coauthors include teenagers and older workers in their sample, whose outcomes may have fewer spillovers onto infants

the Earned Income Tax Credit on birth weight, though minimum wage changes are not the focus of their study. Komro and coauthors (2016) use state-level minimum wage laws and a difference-in-differences approach to more directly estimate positive effects on birth weight and negative effects on postneonatal deaths using data from 1980 to 2011. Wehby, Dave, and Kaestner (2019) use data spanning 1989 to 2012 to build on the work of Komro et al. (2016) by evaluating heterogeneous effects by maternal education, age, and marital status and evaluate possible mechanisms. They find the largest effects on birthweight for the babies of young, unmarried mothers driven primarily by increased fetal growth rate. Contributing to our understanding of potential mechanisms behind minimum wage effects on infant health, Andrea and coauthors (2020) find significant and positive effects of increases in state-level subminimum wage for tipped workers on birthweight for gestational age for the smallest of infants. Using more recent data on birth between 2001 and 2018 and methods from the medical literature, Wolf, Monnat, and Montez (2021) estimate the number of infant deaths attributable to state preemption laws preventing local minimum wage increases. To my knowledge, there is only one paper specifically looking at the relationship between the racial infant mortality gap and the minimum wage in the United States (Rosenquist et al., 2019), but the study is descriptive and uses data from only 2010. Notably, however, the authors find that, observationally, the state-level minimum wage is associated with reduced infant mortality of children of non-Hispanic Black mothers but not associated with infant mortality of children of non-Hispanic white mothers. My study builds on these papers by evaluating how the minimum wage specially affects racial gaps in infant health and by utilizing over a decade of data from a much earlier time period that was not readily available when these studies were conducted. Further, my study contributes to the economic history literature by evaluating another important economic factor in the sudden decline in Black infant mortality during the late 1960s, the causes of which are still debated.

3 Data

My primary data source on natality and infant mortality is the U.S. County-Level Natality and Mortality Data hosted by the Inter-University Consortium for Political and Social Research at the University of Michigan. This relatively new dataset, constructed by Bailey and coauthors (2018), contains vital events at the county-level in the United States between 1915 and 2007. These data primarily come from digitized scans of type-written files released by the National Center for Health Statistics. A limitation of this data source is that births and deaths are only disaggregated by "white" and "non-white" infants, and data availability is limited by censoring of small counties and counties with few "non-white" births. However, in the counties for which data by race are available, the majority of the non-white share is Black, especially during the 1960s. I supplement these data with Vital Statistics Mortality and Natality hosted by the National Bureau of Economic Research in additional robustness checks that incorporate cause of death.

My data to construct county-level measures of industry shares come from the five-percent sample from the 1960 Decennial Census from the Integrated Public Use Microdata Series. The advantage of this data source is that it provides a reliable estimate of the employment shares in each county and in each industry at a relatively granular level of detail. The limitation of this data source is that most counties are sufficiently small that county identifiers are masked, and thus my sample size is limited[2].

[2] I also explored using Community Business Patterns data to include more counties, but the complex censoring rules render much of the data unusable. Even with recent developments in methods to impute

Finally, I use the years in which different industries were covered under the Federal minimum wage as reported in Derenoncourt and Montialoux (2021) and manually crosswalk industries codes to those used in the 1960 Census.

4 Empirical Strategy

In order to uncover the effect of the minimum wage increase on the racial gap in infant mortality, I use a triple difference-in-differences model, which is equivalent to a difference-in-differences model with the outcome defined at the difference in infant mortality between white and non-white infants (Olden and Moen, 2020). Since birth microdata are unavailable for the 1960s, I estimate the model at the county level, exploiting variation in industry employment shares at the county level[3]. Intuitively, counties that pre-reform had higher shares of employment in industries affected by the Fair Labor Standards Act of 1966 were more "treated" by the reform and experienced greater narrowing of the racial wage gap. I begin with a basic model including county by race and year by race fixed effects, and then I add state by year by race fixed effects, county-level linear time trends, and the combination of both additional sets of controls. Given the degree of societal change during this era, my preferred specification is that with both sets of controls, given by the following equation:

$$\text{mort}_{ctr} = \beta_0 + \beta_1 * \text{post}_t * \text{industry share}_c + \beta_2 \text{post}_t * \text{industry share}_c * \text{nonwhite}_r + \beta_3 \text{post}_t + \beta_4 \text{nonwhite}_r + \beta_5 \text{post}_t * \text{nonwhite}_r + \xi_{rst} + \gamma_{rc} + \alpha_c * t + \epsilon_{ctr}$$

missing values, the correlation between 1960 industry shares and Community Business Patterns industry shares is 0.37.

[3] I cannot use the exact primary identification strategy employed by Derenoncourt and Montialoux (2021), since I cannot link their sources of wage data directly to birth outcomes.

The coefficient of interest is β_2, which represents the effect of increasing the minimum wage on the racial mortality gap. More specifically, since the outcome variable is operationalized as number of deaths divided by 1,000 births, and industry shares are operationalized from zero to one, a one percentage point increase in treated employment in a county changes the non-white–white gap in infant mortality (which is measured as deaths per 1000 births) by $\frac{1}{100} * \beta_2$.

To avoid confounding effects from other significant minimum wage expansions, I define the pre-reform period over the years 1962 to 1966 and the post-reform period over the years 1967 to 1973. To create a more balanced panel, I also restrict the sample to counties for which infant mortality by race is available between 1963 and 1971. To account for possible errors in the historical tables from which my outcome data are derived, I have trimmed infant mortality at the 99th percentile by race. All regressions are weighted by the total number of births in 1966 and standard errors are clustered at the county level.

The identifying assumption behind this analysis is that of parallel trends (i.e., that infant mortality gaps would have evolved in parallel between treated and untreated counties in absence of the Fair Labor Standards Act of 1966.) Importantly, Olden and Moen (2020) demonstrate that parallel trends in white and non-white mortality rates are not necessary, only parallel trends in the gap are necessary for identification. I evaluate pre-trends by interacting industry shares with the full set of year dummies.

In constructing the industry shares variable, I omit industry categories that correspond to hospital employment from the treated share, as the desegregation of hospitals in the late 1960s is one potential confound.

I also estimate the same models replacing infant mortality with the birth rate (defined as the number of births per woman between the ages of 15 and 44).

5 Results

5.1 Primary Specifications

Using employment shares from the 1960 Census, an increase in covered employment by one percentage point reduces the infant mortality gap by about 0.16 deaths per 1,000 births, and the coefficient does not vary much with specification. Using my preferred specification with full controls (Table 1, Model 4), this change corresponds to reducing the gap in mortality between non-white and white infants by 1.2 percent. The estimate is less precise with the inclusion of state by year fixed effects, but it is still significant at the 10 percent level. The gap in the birth rates per woman between the ages of 15 and 44 also decreases, but as can be seen in Table 2, these estimates are very sensitive to specification. In my preferred specification, the effect on the gap in birth rates is both small and non-significant. In specifications that do not control for state by year fixed effects, the effect of an increase in covered employment by one percentage point on the fertility gap is 2.4 percent of the average gap in the birth rates. While this effect is sizable, it is still too small to explain a large portion of the effect on infant mortality.

Figure 2 shows the full event study for the change in infant mortality, and there is no indication of a strong pre-trend—though the point estimate for 1963 is somewhat higher relative to the base year of 1966. It is also clear in Figure 2 that the effect is somewhat delayed, but that finding is not surprising given that infants who died in 1967 and 1968 may have gestated (entirely or partially) prior to when the increase in minimum wage took effect. The effect on birth rates, if any, seems to have started more immediately. Further, the Federal minimum wage in affected industries continued to rise slightly between 1967 and 1971 to $1.25.

5.2 Robustness: Desegregation of Southern Hospitals

One possible confound in this study is the concurrent desegregation of Southern hospitals. Using county-level data from Mississippi, Almond, Clay, and Greenstone (2006) argue that the desegregation of hospitals mandated from Title VI of the 1964 Civil Rights Act substantially reduced the Black–white infant mortality gap. However, in more recent work from Anderson, Charles, and Rees (2021), the authors expand the sample of counties to include four additional states, and they employ different methods to conclude that hospital desegregation had no effect. Despite the ongoing debate over the role of hospitals, ignoring their potentially large effects on infants at the same time as the minimum wage reform would be remiss. I address this confound with a series of three increasingly demanding robustness checks.

My first robustness check is to drop the causes of death that Almond, Clay, and Greenstone (2006) identify as particularly sensitive to hospital treatment: pneumonia, influenza, and certain gastrointestinal diseases. These causes of death were relatively preventable with the use of antibiotics, which would have become more available to Black infants as a result of hospital desegregation. Results in Table 3 indicate that dropping these causes of death do not substantially change my primary results, and, if anything, the effect is larger.

Next, I focus on causes of death that would have been particularly unavoidable even with hospitalization over much of my study period: postnatal asphyxia and atelectasis and other hypoxic and anoxic conditions. Effective mechanical ventilation of infants with underdeveloped lungs did not begin in the United States until the introduction of the Babybird ventilator in 1970. Using methods first employed by Kleinman et al. (1978) and further refined by Williams and Chen (1982), infant deaths from undeveloped lungs can be decomposed into two parts: the proportion of infants who are premature (which can be proxied by birth weight) and mortality rates at any given level of pre-maturity (which can be proxied by birth-weight specific mortality)—where only declines in the later factor indicate improvements in neonatal intensive care. Birth weight data are only available from Vital Statistics starting in 1968, but as the medical technology to reduce birth-weight specific mortality was limited before 1970, I can calculate birth-weight-specific mortality from underdeveloped lungs by race starting in 1968 and assume that pre-1968 values were approximately the average of the rates in 1968 and 1969. Then, I can control for the birth-weight-specific mortality from underdeveloped lungs (which is a proxy for both hospital access and hospital effectiveness) in models where the outcome is overall mortality from underdeveloped lungs within the first month after birth. Results in Table 4 indicate noisier but still marginally significant effects with the inclusion of year by state by race fixed effects. In percent terms, the magnitude of the effect is also larger than that seen in my primary results, since the average racial gap in infant mortality from undeveloped lungs is 2.36 per 1,000 births (whereas the overall gap is 13.62 infant deaths per 1,000 births).

My limited sample size precludes me from dropping the Southern states from analysis, but I also estimate the same models using Census data and dropping the five states that Anderson, Charles, and Rees (2021) point to as being most affected by Title VI: Alabama, Georgia, Louisiana, Mississippi, and South Carolina. Estimates are shown in Table 5. In dropping these five states (which account for a large share of Black births), I lose the precision to estimate significant effects on the racial infant mortality gap. However, the point estimates are similar in magnitude, which is reassuring.

5.3 Robustness: Cross-State Analysis

Another limitation of my primary empirical strategy is that I am limited to the 161 counties for which there are both enough Black births for disaggregated birth rates and a high enough population so that county identifiers are not masked in the public 1960 Census data. To ameliorate the concern that results are not robust to the inclusion of smaller counties, I employ an alternate identification strategy similar to Derenoncourt and Montialoux's (2021) cross-state robustness checks. Just as some counties within a state were more treated by the minimum wage reform as a function of local industry composition, some states were more treated as a function of existing state-level minimum wages prior to the reform. Thus, I also estimate triple difference models using measures of the bite of the federal minimum wage stemming from state-level differences in workers covered by the minimum wage prior to 1967. Following Derenoncourt and Montialoux (2021), I use three different measures of state-level minimum wages. Each of these measures is defined on "state groups," as IPUMS report CPS data using these groups for the years 1968 to 1976. In the baseline specification, a state group is considered strongly treated by the minimum wage reform if no minimum wage law applied to more than half of the population in the state-group in 1966. I also estimate models using the share of workers with wages below $1.60 in 1966 as defined in Table 1 of Bailey, Di Nardo, and Stuart (2021) and using the Kaitz index that Derenoncourt and Montialoux (2021) calculate. The Kaitz Index is a weighted minimum-to-median-wage ratio also defined as the state-group level. I estimate these models at the county-level, weight by number of births in 1966, and cluster the standard-errors at the state-group level. I also include county by race and year by race fixed effects and county linear time trends. The general specification is given by the following equation:

$$\text{mort}_{ctr} = \beta_0 + \beta_1 \text{post}_t + \beta_2 \text{nonwhite}_r + \beta_3 \text{state min wage strength}_c + \beta_4 * \text{ post}_t * \text{state min wage strength}_c +$$
$$\beta_5 \text{ post}_t * \text{state min wage strength}_c * \text{nonwhite}_r + \xi_{tr} + \gamma_{cr} + \alpha_c * t + \epsilon_{ctr}$$

As seen in Figure 4, there is no effect prior to 1967, after which there is a clear decline in the infant mortality gap. Results across the three measures of state-level minimum wages are remarkably similar. Using the primary definition of a strongly treated state-group, strongly treated states experienced about a 22% reduction in the mean racial gap in infant mortality under the new Federal minimum wage. Using the share of workers with wages below $1.60 as defined in Bailey et al. (2021), moving from the 25th percentile of this index to the 75th percentile of this index corresponds to a 20% reduction in the mean racial gap in infant mortality. Using the Kaitz Index, moving from the 25th percentile of this index to the 75th percentile of this index corresponds to a still sizable 14% reduction in the mean racial gap in infant mortality.

Since treatment is defined at the state-group level, I cannot control for year by state by race fixed effects, which as discussed earlier, may be particularly important in the historical context of rapid social and political change of the United States in the 1960s. Still, these results complement my primary identification strategy in that they incorporate all 872 counties with sufficient Black births during this time period to measure changes in the racial gaps in infant mortality.

6 Discussion

I interpret these results as clear evidence that the Fair Labor Standards Act of 1966 did reduce the infant mortality gap. In future work, I aim to find more comprehensive data sources to estimate models using more counties, with an emphasis on including more counties outside of the South. In particular, I may be able to apply for restricted Census data with less masking of geographic identifiers.

There are also other potential confounds that future iterations of this paper will address more directly. The 1960s were a period of rapid political and social change in the United States, and there are other policies arising from the Civil Rights Movement and the War on Poverty that could bias results. Potential factors to consider include the proliferation of Community Health Centers, the implementation of Medicaid and Medicare programs starting in 1965, expansions to Maternal and Child Health (MCH) Services Program within Title V, and changes to union structure and participation.

Since I cannot observe actual wages at the county level over the study period (county-level identifiers were added to the Current Population Survey in 1995), I cannot directly verify that county-level industry shares in 1960 generates sufficient variation in the racial wage gap at the county level. However, the variation in industry shares across counties in combination with the magnitude of effects found in Derenoncourt and Montialoux (2020) somewhat ameliorates this concern. I am also limited in my ability to distinguish between specific different mechanisms by which increased minimum wages could affect birth outcomes. Robustness checks evaluating changes in infant mortality from underdeveloped lungs suggest that improvements in prenatal environment account for some of the overall effects, but I cannot isolate which aspects of prenatal environment were most important. Access to financial resources can mediate birth outcomes through a variety of channels including prenatal nutrition, prenatal and neonatal access to health care, maternal tobacco and alcohol use, and prenatal exposure to pollution and toxins (Currie, 2011). It is also possible that any effects could be mediated by changes in timing of births, though the past literature studying the effects of the minimum wage on teenage births is mixed (Bullinger, 2017; Lenhart 2020; Wehby et al., 2020).

7 Conclusion

Although my study focuses on the 1960s, the United States still lags behind other high-income countries with respect to infant mortality rates, and racial inequality is an important factor in explaining this pattern (Rosenquist et al., 2019). In 2018, the infant mortality rate for non-Hispanic Black babies was 10.8 per 1,000 births, over twice the infant mortality rate for non-Hispanic white babies of 4.6 per 1,000 births (CDC). One of the challenges in addressing racial health disparities is understanding the degree to which these gaps come from economic inequality versus direct discrimination in accessing care. A large literature suggests that both factors are at play (Miller et al., 2022), and my study provides quasi-experimental evidence that reducing racial economic disparities can improve the health of non-white Americans. In my primary specifications, an increase in employment shares covered by the Federal minimum wage by one percentage point reduces the infant mortality gap by about 0.2 to 0.4 deaths per 1,000 births. As the public debate over minimum wage increases continues, it will be increasingly important to understand the full extent of outcomes affected by potential changes to the level and coverage of the Federal minimum wage.

Although data limitations preclude me from directly evaluating impacts on birth weight and other measures of infant health in this historical context, changes in infant mortality are an indication of broader changes in infant health (McCormick, 1985). Infant health is important for long-run economic outcomes (Black, Devereux, and Salvanes, 2007), suggesting an additional mechanism through which minimum wage increases may contribute to improved intergenerational mobility.

Tables

TABLE 1: Census Data & Infant Mortality

VARIABLES	(1) IMR	(2) IMR	(3) IMR	(4) IMR
post x industry share	-4.452	-3.139	2.015	-5.191
	(3.166)	(4.362)	(5.743)	(6.488)
post x industry share x non-white	-17.06**	-15.58*	-17.06**	-15.58*
	(6.793)	(8.634)	(6.939)	(8.817)
Observations	3,864	3,864	3,864	3,864
R-squared	0.410	0.560	0.464	0.594
CountyxRace FE	YES	YES	YES	YES
Time FE	YearxRace	YearxRacexState	YearxRace	YearxRacexState
County Linear Time Trends	NO	NO	YES	YES

Standard errors clustered at the county level in parentheses
*** p<0.01, ** p<0.05, * p<0.1

TABLE 2: Census Data & Birth Rates

VARIABLES	(1) Birth Rate	(2) Birth Rate	(3) Birth Rate	(4) Birth Rate
post x industry share	0.00226	-0.00666	0.0127	-0.0116
	(0.00973)	(0.00865)	(0.0118)	(0.0123)
post x industry share x non-white	-0.0766***	-0.0215	-0.0780***	-0.0244
	(0.0213)	(0.0165)	(0.0218)	(0.0167)
Observations	3,845	3,845	3,845	3,845
R-squared	0.788	0.898	0.850	0.920
CountyxRace FE	YES	YES	YES	YES
Time FE	YearxRace	YearxRacexState	YearxRace	YearxRacexState
County Linear Time Trends	NO	NO	YES	YES

Standard errors clustered at the county level in parentheses
*** p<0.01, ** p<0.05, * p<0.1

TABLE 3: Census Data & Infant Mortality: Dropping Antibiotic-Treatable Diseases

VARIABLES	(1) IMR	(2) IMR	(3) IMR	(4) IMR
post x industry share	-5.277	-2.466	3.176	-2.727
	(3.303)	(4.387)	(5.901)	(5.666)
post x industry share x non-white	-21.32***	-19.52**	-21.32***	-19.52**
	(7.731)	(8.837)	(7.898)	(9.024)
Observations	3,864	3,864	3,864	3,864
R-squared	0.561	0.677	0.605	0.705
CountyxRace FE	YES	YES	YES	YES
Time FE	YearxRace	YearxRacexState	YearxRace	YearxRacexState
County Linear Time Trends	NO	NO	YES	YES

Standard errors clustered at the county level in parentheses
*** p<0.01, ** p<0.05, * p<0.1

TABLE 4: Census Data & Infant Mortality: Premature Lungs

VARIABLES	(1) IMR	(2) IMR	(3) IMR	(4) IMR
post x industry share	3.112	0.356	5.804***	2.998
	(2.175)	(2.135)	(2.127)	(2.572)
post x industry share x non-white	-4.253	-8.164**	-4.282	-8.249*
	(3.724)	(4.040)	(3.807)	(4.206)
Observations	3,864	3,864	3,864	3,864
R-squared	0.415	0.612	0.544	0.690
CountyxRace FE	YES	YES	YES	YES
Time FE	YearxRace	YearxRacexState	YearxRace	YearxRacexState
County Linear Time Trends	NO	NO	YES	YES

Standard errors clustered at the county level in parentheses
*** p<0.01, ** p<0.05, * p<0.1

TABLE 5: Census Data & Infant Mortality: Dropping AL, MI, SC, LA, & GA

	(1)	(2)	(3)	(4)
VARIABLES	IMR	IMR	IMR	IMR
post x industry share	-6.456**	-4.794	-0.248	-7.790
	(2.688)	(4.482)	(6.033)	(7.461)
post x industry share x non-white	-12.49*	-11.63	-12.49*	-11.63
	(7.005)	(10.00)	(7.155)	(10.21)
Observations	3,072	3,072	3,072	3,072
R-squared	0.409	0.566	0.464	0.601
CountyxRace FE	YES	YES	YES	YES
Time FE	YearxRace	YearxRacexState	YearxRace	YearxRacexState
County Linear Time Trends	NO	NO	YES	YES

Standard errors clustered at the county level in parentheses

*** p<0.01, ** p<0.05, * p<0.1

TABLE 6: State-Level Analysis

VARIABLES	(1) IMR	(2) IMR	(3) IMR
Post	-22.70***	-21.18***	-18.71***
	(0.544)	(0.527)	(2.577)
Nonwhite	27.20***	28.54***	27.98***
	(0.706)	(0.871)	(0.846)
Strong	-2,748***		
	(118.9)		
PostXStrong	0.672		
	(0.704)		
PostXStrongXNonwhite	-3.230***		
	(0.987)		
BaileyStrong		-12,423***	
		(560.4)	
PostXBaileyStrong		5.955**	
		(2.827)	
PostXBaileyStrongXNonwhite		-18.18***	
		(4.369)	
Kaitz			-154.4***
			(6.968)
PostXKaitz			0.123**
			(0.0471)
PostXKaitzXNonwhite			-0.256**
			(0.114)
Constant	20.52***	2,206***	4,650***
	(0.490)	(98.51)	(208.5)
Observations	20,903	20,903	20,903
R-squared	0.685	0.685	0.685
CountyxRace FE	YES	YES	YES
YearxRace FE	YES	YES	YES
County Linear Time Trends	YES	YES	YES
Measure	Primary	Bailey	Kaitz

Standard errors clustered at the state-group level in parentheses
*** p<0.01, ** p<0.05, * p<0.1

Figures

Figure 1: Racial Gaps in US Infant Mortality: 1960s-1970s

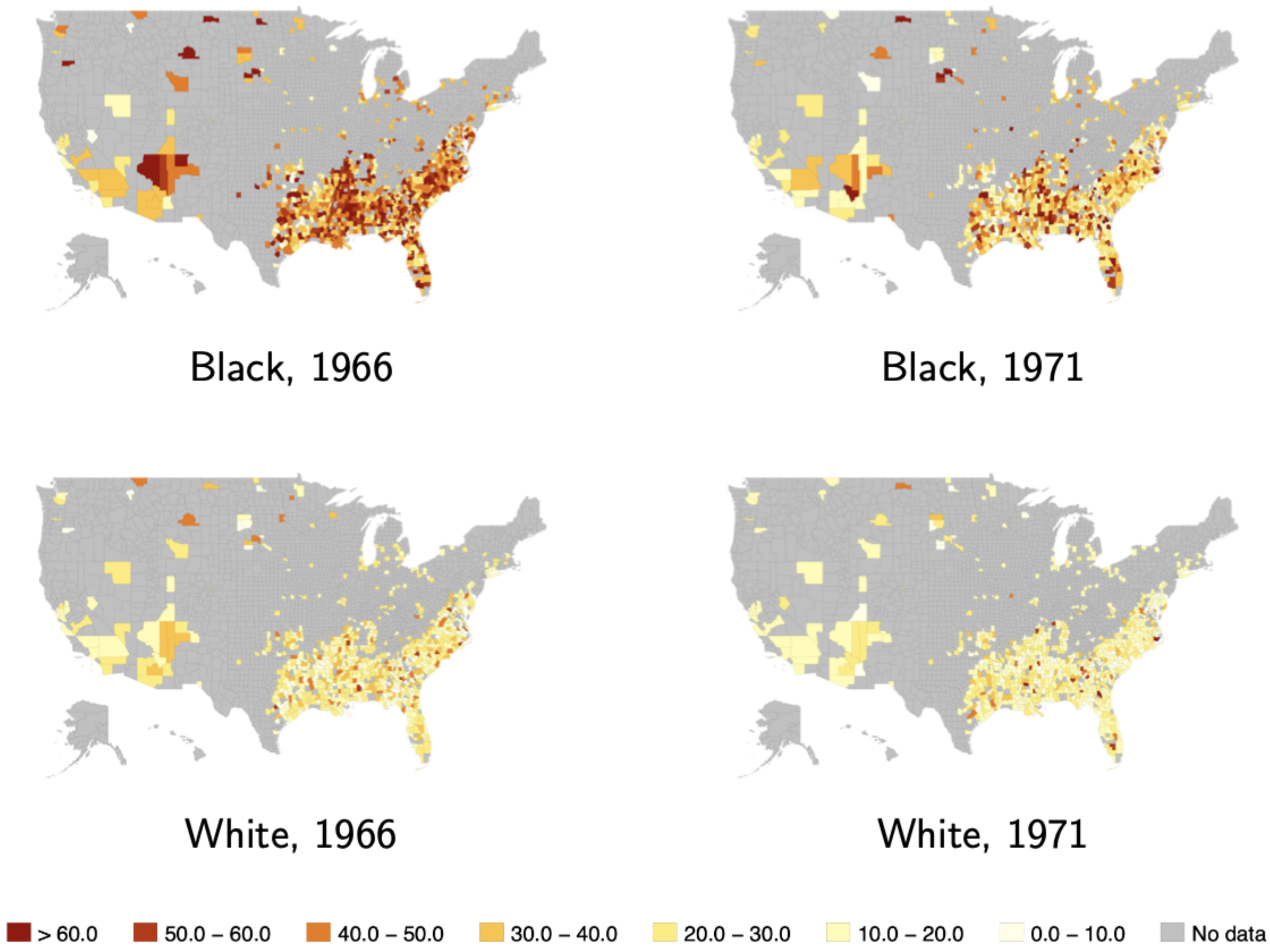


FIGURE 2: Census Data & Infant Mortality

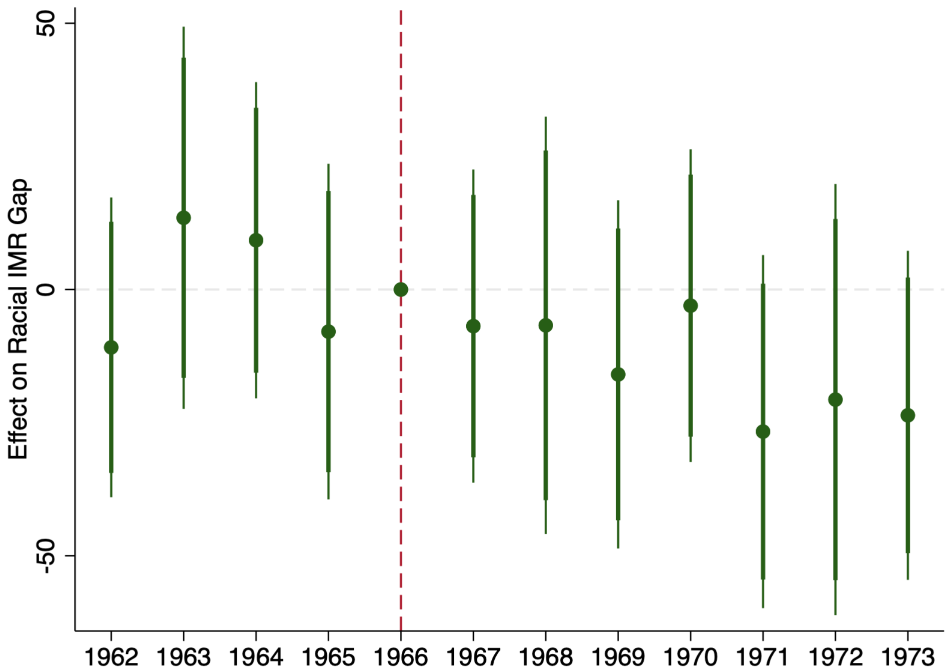


FIGURE 3: Census Data & Birth Rates

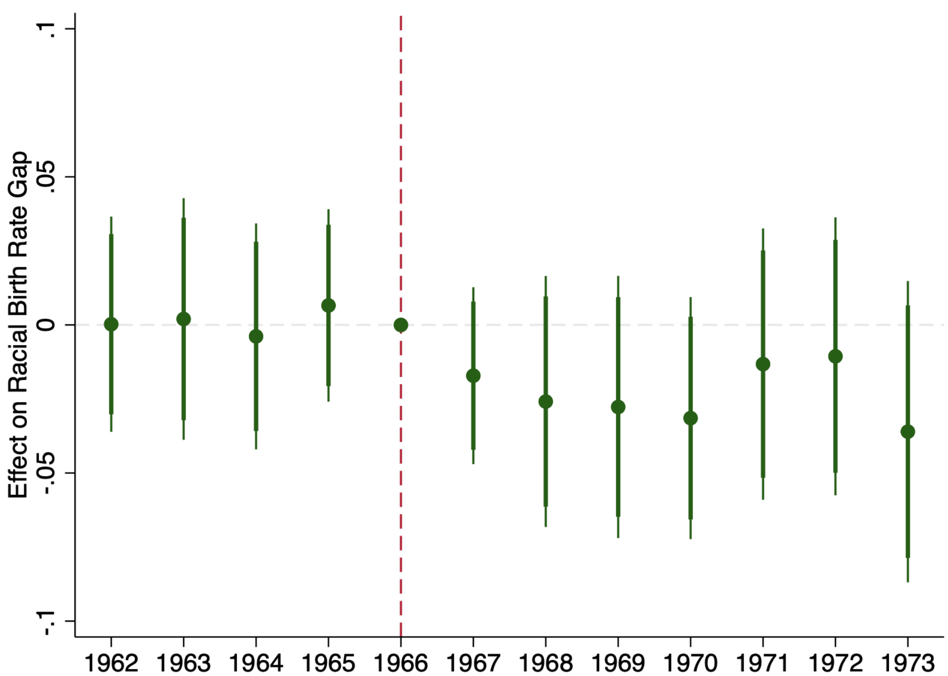
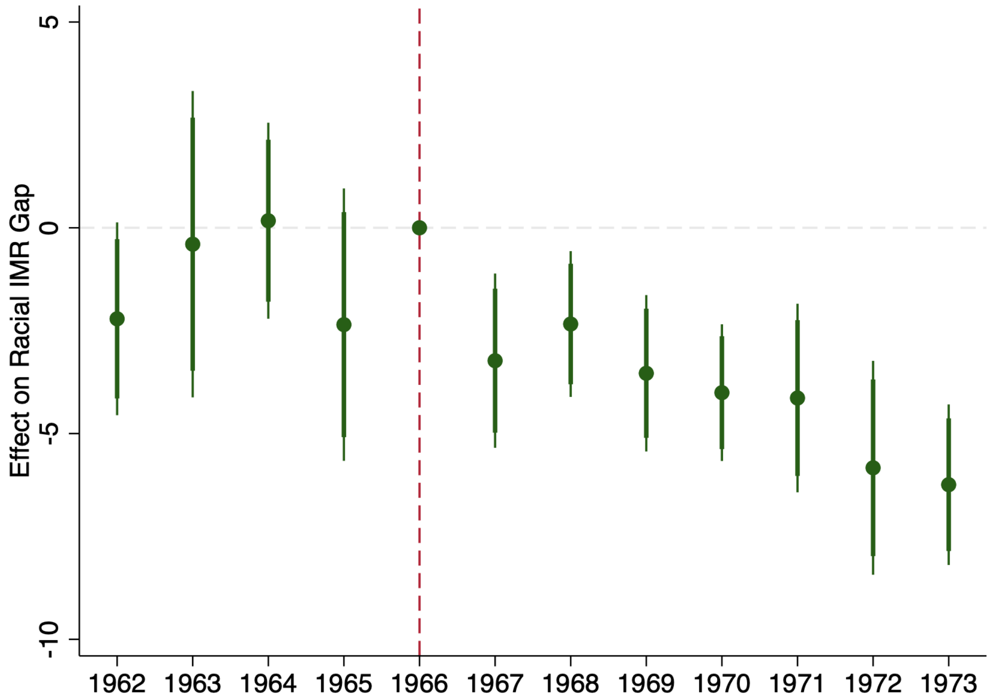


FIGURE 4: Cross-State Analysis of IMR Gap



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Appendix

Table A1: Sample Means

	Black	White	Difference
IMR	32.55	18.94	13.62
Fertility	0.116	0.084	0.032
IMR, Drop Pneumonia & Gastroenteritis	30.71	18.22	12.49
IMR, Underdeveloped Lungs	6.66	4.30	2.36
IMR, Drop Deep South	31.90	18.71	13.19