

b. establishing a national institute (comparable to the National Institutes of Health) to conduct studies and demonstration projects leading to strengthening of family life;

c. urging the Federal Government to encourage States to utilize appropriate available services of voluntary agencies, as well as involving them in studying problems of family disintegration and breakdown and in developing coordinated programs for strengthening of family life; and

d. assisting the States to increase the number of staff qualified to provide services needed by public welfare recipients to help prevent dependency and promote social rehabilitation by: (1) providing 100 percent Federal funds both to States for training public welfare personnel, and to accredited graduate schools of social work for training in strengthening family life and caring for the needs of the aging; and (2) encouraging States to establish and maintain salaries of public welfare personnel at levels required to obtain and retain competent personnel.

Other recommendations concerning fiscal and

administrative operations included the confirmation of the "open-end" method of appropriating funds and the statement that the proportionate Federal share of total public assistance expenditures, including general assistance, for the Nation as a whole, should not be less than is currently provided under the Social Security Amendments of 1958. Measures were also recommended to extend coverage and increase social insurance benefits with a particular view toward reducing the need for public assistance. The Federal Government was also urged to encourage the States to establish appropriate advisory committees and in other ways to stimulate public interest and increase public knowledge of the role of public welfare programs, since "the more a community becomes a part of a public welfare program, the better it will be."

Title V of the Social Security Act: What It Has Meant to Children

by **KATHERINE B. OETTINGER***

SOMETIMES IT IS GOOD to pause and look back at 25 years of activity in behalf of children. Professional workers engrossed in programs of services to children often find their hopes outstripping their accomplishments—and for this reason experience periods of great frustration and deep discouragement. In looking back over 25 years, programs can be seen more clearly, both in terms of perspective and achievement.

The twenty-fifth anniversary of the Social Security Act gives us an opportunity to move back in time to the mid-thirties to see how and why the children's programs under Title V of the Act came into existence and the way they have moved in the intervening years.

Long before the depression which placed 8 million American children under 16 years of age on the relief rolls, the severe toll that poverty

and economic exploitation took of the lives and welfare of children were only too well known. The earliest studies of the Children's Bureau, dealing with infant mortality, showed that low earnings and high infant death rates went hand in hand. Later studies of juvenile delinquency revealed its association with poverty, bad housing, and demoralizing neighborhood conditions.

Various studies of the Bureau during the 1920's dealing with wages and standards of living showed that many families lived on a bare subsistence level with no means of saving for the proverbial rainy day. Others lived on such a small margin of safety that the first wind of adversity swept away their small savings and brought them to the verge of destitution.

Unfortunately, too, it was the children who paid the price of this lack of security. And since the effects of economic distress bore heaviest on the children, they reached far into the future.

*Chief, Children's Bureau.

BACKGROUND FOR CHILD WELFARE SERVICES

During the several decades before 1935, many voluntary agencies and a growing number of public agencies in many urban areas and a few States developed services for the care and protection of children who were neglected, abused, or abandoned by their families or whose families were unable to provide for them for a variety of reasons—illness, death, desertion.

Institutional care was giving way to foster family care in cities. Adoption programs, programs for the care of unmarried mothers, day-care centers—all these had begun in cities. But little of this kind of help existed in rural areas.

During the depression years, even the few existing child welfare services were sharply curtailed. This brought suffering to and endangered children.

By 1934, then, the urge was strong for Federal grants to help all States extend financial aid and welfare services to children, particularly to the rural areas where little had previously been provided. Thus, under the Social Security Act of 1935, the first Federal grant-in-aid program was set up to assist the States in the development and improvement of local public child welfare services.

MATERNAL AND CHILD HEALTH SERVICES: A CASUALTY OF THE DEPRESSION

Congress' first effort to assist the States with grants for maternal and child health purposes—the Maternity and Infancy Act of 1921—had been limited in time to the years between 1921 and 1929, and in coverage to health care in the maternity and infancy periods. The beginning of the great depression in 1929 had coincided with the withdrawal of these grants.

The work of the Society for the Prevention of Infant Mortality, predecessor of the American Child Health Association, had done much to make the country aware of the urgency of child health programs. The White House Conference on Child Health and Protection in 1930 had brought together a wealth of material for the use of professional health and welfare workers. That year, too, saw the establishment of the Academy of Pediatrics, with its basic objective of "correlating all aspects of work for the wel-

fare of children which properly come within the scope of pediatrics."

In those years, also, modern concepts and new knowledge of child growth and development were beginning to emerge from psychiatric and child-guidance clinics and from the child-research centers in various universities.

But despite these hopeful developments, as the depression deepened in the early thirties, State and local health agencies found their funds for personnel and services severely reduced. In many States, child health programs built up under the Maternity and Infancy Act in the twenties were curtailed or abandoned.

By the fall of 1934, ample evidence pointed to the need for renewal of grants to States for maternal and child health programs and for the establishment of Federal aid for the care of crippled children.

THE SOCIAL SECURITY ACT

After Congress convened in January 1935, President Franklin D. Roosevelt asked it to lay the foundation for the development of safeguards that would prevent or at least reduce the effects of the major hazards threatening family life and individual welfare.

The recommendations presented by the President to Congress were in the form of a report representing months of study by the Committee on Economic Security—a committee appointed by the President and including the Secretary of Labor, Chairman; the Secretary of Agriculture; and the Federal Emergency Relief Administrator. This Committee had the assistance of a technical staff, a technical committee, an advisory council of which Grace Abbott, the second chief of the Children's Bureau, was a member, and several advisory committees, including an advisory committee on child welfare.

The Committee asked the Children's Bureau to assume responsibility for assembling the facts on child health and child welfare that should be considered in setting up a security program. These findings in turn were approved by the Committee and were eventually incorporated into the Social Security Act itself.

Title V as drafted included Federal aid for three types of work with children—maternal and

child health services, services for crippled children, and child welfare services—to be administered through the Children's Bureau. The measure was signed by the President on August 14, 1935.

PROGRAMS GET UNDERWAY (1935-40)

In getting underway—and in carrying out the three children's programs for which it was given responsibility under the Social Security Act—the Bureau in characteristic fashion turned to advisory groups for advice and guidance. In addition, special committees on various technical problems of the programs were appointed, for example, a special committee on maternal welfare and an advisory committee in training and personnel for child welfare.

The soundness of the planning and the dispatch with which the programs got underway were evidence of the value of the advice given to the Bureau by these groups. They helped the Bureau chart the course of these children's programs in the coming decades. The highlights of this story are told here.

Health Services

The Social Security Act of 1935 established a new landmark in the development of health services for the mothers and children of the United States.

Maternal and child health.—Title V, part 1, authorized a total annual appropriation of \$3 million for maternal and child health work. Funds were to be used to extend and improve services for promoting the health of mothers and children, especially in rural areas and areas suffering from severe economic distress.

The funds granted to the States for maternal and child health services were used, under the administration of the State health departments, to pay for physicians, dentists, public health nurses, medical social workers, and nutritionists, to help mothers and children living, for the most part, in rural areas. These mothers and children were reached through prenatal and child health clinics held in centers accessible to them and through school health services. Many others were

reached through home visits by public health nurses.

Some few mothers and children were given medical and hospital care, but the program as set up by States in the first years was primarily one to develop preventive health measures and training professional personnel rather than actual medical or hospital care.

In the years 1936-40, many changes in program occurred. The scope of service widened to include demonstrations and special projects showing how new knowledge could be put to work. Improvement of maternity care and care of newborn infants was progressive, and special programs for the care of premature babies developed training centers. All the States used some of their funds for the training of professional personnel to provide these services.

From the start the maternal and child health programs under the Social Security Act gave the Bureau an opportunity to work with States in planning special projects and programs aimed at **the conditions and circumstances affecting infant and maternal mortality.**

This was possible because the act called for demonstrations to be part of the program in each State, and part of the funds given to each State was granted without matching requirements. With these funds the State frequently undertook new work, developed experimental programs that were not possible with their State and local funds.

Crippled children's services.—The program for crippled children was the first program of medical care based on the principle of continuing Federal grants in aid to the States. Title V, part 2, provided Federal grants for extending and improving services to crippled children. The total appropriation authorized was \$2,850,000.

The first step in the operation of the crippled children's program as set forth by Congress was to find the children. The injunction was unusual. The Federal Government was saying in effect, do not wait for these children who need care to be brought to you; find them—wherever they may be—and bring them in. All States arranged for clinics to be held throughout the State, either at an itinerant or permanent base; diagnostic services were made available to all children.

The variety of care that had to be coordinated was complex since the care of children with

crippling conditions is complex—medical, health, nursing, medical-social, physical and occupational therapy and psychological services, and care in hospitals, clinics, and private offices.

From the earliest days of the program, there was injected the concept of treating the whole child rather than a paralyzed arm, a damaged heart, or a “case” of deafness or epilepsy. As a corollary, there developed the concept of care by a team of professional workers, including doctor, nurse, social worker, therapist, psychologist, nutritionist, and educator.

These programs were administered in each State by an agency designated by the State—in about three-fifths of the States by State health departments.

From the beginning, State programs accepted handicapped children who needed orthopedic or plastic treatment. But as understanding pushed back boundaries and as additional funds became available, States broadened their interpretation of crippling conditions. Gradually the State programs were directed toward one objective—physical, social, and emotional restoration of the crippled or handicapped child.

In 1939 Congress made additional funds available for crippled children’s services, with the understanding that part would be used to assist States in developing programs for the care of children with rheumatic heart disease. Ultimately special projects were started for the care of these children in some 29 States. The programs started in 1939 and 1940 were the forerunners of many types of special projects that extended and strengthened the crippled children’s program.

Child welfare services.—Title V, part 3, of the act authorized an annual appropriation of \$1.5 million to be made available to the States for “establishing, extending, and strengthening, especially in predominantly rural areas,” child welfare services for the protection and care of “homeless, dependent, and neglected children and children in danger of becoming delinquent.”

Some States with no pattern of public programs for child welfare in 1935 had to start from scratch. A few States had the beginnings of a program of public services to children. These built on what they had, improving the quality or coverage of service.

The Bureau started by calling together the available leadership to consider what the first steps should be in getting the program underway. The group that was called together first, later became an advisory committee on community child welfare services.

Later in 1936 a representative group of faculty members from the schools of social work was appointed as an Advisory Committee on Training and Personnel for the Children’s Bureau and the Bureau of Public Assistance and continued to advise the Bureau for many years. Later the last committee was expanded to include staff of public welfare agencies. These groups were instrumental in shaping the direction of the public child welfare program.

These leaders stated, strongly and unanimously, that the most important requisite in services to children was competent personnel. They urged that the child welfare services funds be spent primarily for the employment and training of staff.

So it was that soon after the passage of the act, States began using child welfare services funds for graduate training in social work of child welfare personnel. This marked the first use of Federal funds by public welfare agencies for the professional education of staff.

By March 15, 1938, 45 States, Alaska, Hawaii, and the District of Columbia were cooperating with the Bureau in this area.

Who were the children and the families for whom these State programs were designed?

Some of the children were in difficulty in their own homes or in their own neighborhoods; some were handicapped children; some were children in jails or known to the juvenile courts; some were children in institutions for the care of delinquent or dependent children.

Some were boys and girls for whom a foster home had to be found because of neglect, sickness of the parents, delinquency, or dependency. Some were unmarried mothers; some were couples who had no children and wanted to adopt a child.

Many States and communities turned to the Bureau for special help and advice on the adequacy of care provided juvenile delinquents.

The 1937 report of the Bureau described typical requests from States or localities for consultative service received during the year in the area

of juvenile delinquency. These requests were concerned with the adequacy of care provided for juvenile delinquents, planning community programs for the prevention and treatment of delinquency, and juvenile court legislation and administration.

GRANT-IN-AID PROGRAMS DURING WORLD WAR II

War disrupted the lives of families and of children—and, as was inevitable, the programs of services for them under Title V. The Bureau did what it could to cushion the effects of the emergency on children by adapting its programs.

Health Services

Fortunately, grants to States for maternal and child health and crippled children's services had been increased somewhat in 1939.

Maternal and child health.—Because of the withdrawal of doctors and nurses from communities into the Armed Forces, the main problem faced by the States was to replace personnel as they left, when possible, and through reorganization of these programs to enable the limited personnel remaining to serve larger numbers of mothers and children.

Maternal and child health programs beginning in 1942 and 1943 showed decreases. Medical services rose slightly during the early years of the war and then by 1945 fell to levels below those of 1940. Nursing services rose during the early war years and then turned downward.

The most important development for these programs during this period was the emergency maternal and infant care program. Early in 1941 State health departments asked the Bureau to approve use of maternal and child health funds for the maternity care of wives of servicemen. The Bureau agreed, and in August 1941 the program got underway. But requests from State health agencies soon outstripped the funds available.

The Children's Bureau then appealed to the Bureau of the Budget in August and September 1942 for funds for emergency maternity and infant care, to be administered by the State health

agencies under the provisions of the maternal and child health program of the Social Security Act. This item was included in the first deficiency bill when Congress convened in 1943.

Congress unanimously approved the measure. In March the bill was signed by the President and became a law. The money appropriated was to cover the cost of medical, hospital, and nursing care for wives and babies of men in the four lowest pay grades of the Armed Forces.

The program was called emergency maternity and infant care—EMIC for short—the largest public maternity program ever undertaken in the United States.

Under this program, wives of servicemen in the 4th, 5th, 6th, and 7th grades of all services and aviation cadets were provided, without cost to them, with medical, nursing, and hospital care throughout pregnancy, at childbirth, and for 6 weeks thereafter. Hospital care was paid for at ward rates.

The babies of these servicemen were also eligible for medical, nursing, and hospital care if sick any time during their first year of life.

From the beginning of the program through the end (June 1949), 1,222,500 mothers were given maternity care and 230,000 infants received medical care at a total cost of \$126,922,316.

Crippled children's services.—The effects of the war were keenly felt in services for crippled children through spiraling costs, the withdrawal of surgeons, nurses, and physical therapists for service in the Armed Forces; shortages in hospital facilities and services; difficulty in arranging transportation to clinics, hospitals, and convalescent homes; and restrictions on the manufacture of metal appliances.

As a result, decreases in crippled children's services occurred each year. Fewer crippled children received care in clinics, hospitals, and convalescent or foster homes, and public health nursing and physical therapy services declined. Although toward the end of the war these services were once again increasing, they still had not reached the high point of 1940-41.

Child Welfare

Many social problems affecting the lives of children were created or intensified by the dis-

locations of family and community life growing out of wartime conditions.

The absence of millions of fathers in military service and the increased employment of mothers outside the home were the greatest causes of family dislocation. Children in migrating families were exposed to abnormal family and community life in war-congested areas. Adolescents were restless and under tension, and many left home to seek employment. Juvenile delinquency was on the increase everywhere.

State public welfare departments used child welfare services funds to provide special staff to deal with wartime child welfare problems. For example, a number of States developed special projects for the study and prevention of juvenile delinquency, using special consultants on the State staff, workers assigned to State training schools, and to local areas to work on the control of juvenile delinquency. More than half the States added workers to the staff of State and local public welfare departments to meet demands for consultation services in the development of community day care programs.

The problem of securing personnel was serious throughout the defense and war years. To meet the problem of staff shortages and turnover, State public welfare agencies increased their staff development programs both through in-service training and through educational leave for professional training.

The widespread need to extend and adapt child welfare programs to meet the wartime problems of children and youth brought increased requests to the Bureau for consultation from State public welfare departments, law-enforcement agencies, national and local private agencies, defense council committees on children, and citizens' groups.

THE DECADE 1946-55

For the Bureau the first years of the period 1946-55 were spent in shifting from intensive wartime activities to a program of on-going permanent activities.

Throughout this decade all aspects of the Bureau's program were colored by the great rise in the child population following the high birth rate during World War II and by the growing

tensions among people, reflected so obviously in the lives of children—tensions arising from the Korean War and from the unknowns and uncertainties of the new atomic age.

During this decade, States and localities extended and broadened their activities in the three grant-in-aid programs. As the total amount for Federal grants increased from 1946 to 1955, the proportion of funds expended by States and localities increased in all three grant programs.

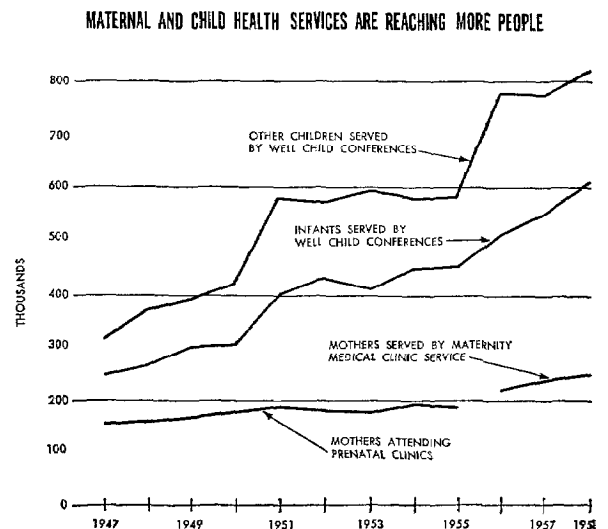
Health Services

Great progress was made during these years in the maternal and child health and crippled children's programs, although the shortage of physicians to undertake the administration of these programs—physicians with both clinical and public health training—plagued both programs. There was a shortage, too, of many other professional workers essential to the programs.

Maternal and child health.—While the maternal and child health program remained primarily one of preventive health services, during this decade many State health agencies added medical and hospital care of certain mothers and children.

The principal developments during the decade were the increase in the demonstration programs and other activities in behalf of prematurely born infants, the increase in programs for the

CHART 1.—*Maternal and child health services under the Social Security Act, 1947-58*



postgraduate training of personnel, and much emphasis on the emotional growth of infants and children and the parent-child relationship.

During this decade child health conferences were broadening their scope to include the mental health aspects of child growth and development. They were being directed more and more toward helping parents with early social and emotional difficulties in their children in order to prevent more serious problems later.

Special projects for the care of premature babies were doing a pioneering job in showing how the lives of these undersized and underdeveloped infants, who weigh less than 5½ pounds (2,500 grams) at birth, could be saved and safeguarded. Many States were concentrating on providing actual care for premature infants in hospitals with special equipment and with specially trained doctors and nurses.

States were giving greater attention to prenatal care, particularly for mothers with complications of pregnancy, in an effort to reduce the incidence of prematurity. States were also doing much to further the development of health services for children of school age by increasing their efforts to coordinate services of health and education through joint planning at the State level.

Great progress was made during the decade in providing training for physicians in maternal and child health work by certain schools of public health (Harvard, California, Johns Hopkins, Pittsburgh, North Carolina, Minnesota) and for nurses in maternal and child care by a number of schools of nursing. Special opportunities were made available for training in highly specialized clinical and health fields, such as audiology, the treatment of rheumatic fever and congenital heart disease, epilepsy, cerebral palsy.

Crippled children's services.—During the years 1946-55, State crippled children's agencies steadily broadened their program to include children with handicaps other than orthopedic.

Conditions, in addition to orthopedic, receiving special attention in State programs during the decade included cerebral palsy, eye disorders amenable to surgery, cleft palate, burns, hearing impairment, rheumatic fever and rheumatic heart disease, congenital heart disease, epilepsy, and orthodontic defects.

The principle that the best type of treatment for a handicapped child requires a team of professional workers became more and more the rule. Physician, nurse, psychologist, medical social worker, physical therapist, teacher, and others as required pooled their knowledge and efforts to provide treatment that would restore the child to the fullest health and activity of which he was capable.

Increasingly, ways were being sought and found to allow handicapped children to mingle with and go to school with other children; to learn from their earliest childhood to accept their handicap and to play, learn, and grow up with their childhood peers; not to expect special attention beyond what their individual handicap called for; and not to be set apart as a special group.

The great research findings of the decade were being applied in the crippled children's programs and made available to children in rural areas through the development of preventive and treatment services for children's hearing impairment, special programs for children with epilepsy, and regional and State centers for the surgical treatment of children with congenital heart disease and for postgraduate training in these specialties.

Among the newest of the special projects granted funds under the crippled children's program in 1954-55 were those in California and Michigan for the development and use of artificial hands and arms, available hitherto only to adults.

Child Welfare

This decade (1946-55) was a period of steady building for child welfare programs in the States. States were examining their legislation concerning children and organizing and strengthening services—adoption, licensing, services to children in their own homes, and foster care.

The number of adoptions and the pressures for children to adopt grew. Public and voluntary agencies began to reexamine their practices in this area.

Public and voluntary agencies were also working together on community planning for child welfare. Of course, community planning for

child welfare was not a new trend in this decade. Rather it represented a stepped-up momentum in a trend that got underway during the first decade of the child welfare programs under the Social Security Act. The act itself had recognized the importance of such planning—and this had been reiterated over the years by the various advisory groups of the Bureau—and in 1950 Congress reaffirmed the importance of community planning for child welfare by the following proviso: “. . . in developing such services for children the facilities and experience of voluntary agencies shall be utilized in accordance with child care programs and arrangements in the States and local communities as may be authorized by the State.”

Federal child welfare services funds continued to be used for training personnel during this decade. The goal for the States continued to be a staff with 2 years of such professional education—a goal that could not be attained in the immediate future.

Foster care of children, both in foster family homes and institutions, was one of the heaviest responsibilities of State and local public welfare agencies both in terms of numbers of children and expenditure of public funds. The majority of these children were cared for in foster family homes. The number of children receiving foster family care under public agency auspices increased from 49,000 in 1933 to 123,000 in 1955, or 151 percent.

Since 1946, and particularly since 1950, States have used a small part of their Federal child welfare services funds to pay for the support of children in foster care to meet special needs. A few expenses involved in returning runaway children to their homes were met with these funds beginning in 1950 when this use was specifically spelled out in an amendment to the Social Security Act.

Beginning in 1952, a committee of staff from the Children's Bureau and the Bureau of Public Assistance was set up to help States in providing more adequate services to children in families receiving payments under the program of aid to dependent children.

An important trend in group care was the development of small group homes in the community for adolescents who could not take root in foster family homes and children who needed

temporary shelter. Specialized group facilities were also being developed for emotionally disturbed children.

TO THE MIDPOINT OF THE THIRD DECADE

The first 5 years of the third decade brought the problems of certain groups of children to the fore in all the Bureau's grant-in-aid programs. Among these were the adolescent, the children of migratory workers, mentally retarded children, and children placed independently for adoption.

The Nation as a whole was concerned about juvenile delinquency because of its tragic consequences for the young person and his family, its contagion among young people, and its social and economic cost to the community.

The Children's Bureau was giving particular attention to the problems of delinquent children through its new Division of Juvenile Delinquency Service. In August 1954, Congress had given a supplemental appropriation of \$75,000 to the Bureau to enable it to expand its services in juvenile delinquency. In October, the Secretary of the Department took the first step in this direction by authorizing the creation of a Division of Juvenile Delinquency Service in the Children's Bureau.

This new division was set up to provide technical assistance to public and voluntary agencies and to develop standards, guides, and methods relating to various types of service and care for delinquent children.

Maternal and child health.—Special emphasis continued to be given to the development of programs for the mentally retarded child. Since 1955, the number of States with programs for mentally retarded children has grown from four to 44. Thirty States in the fiscal year 1959 were using these special project funds to help finance mental retardation programs, and 14 States were using either their own or regular maternal and child health grants to finance such projects.

Progress was made in 1958-59 in extending geographically and in strengthening and improving services for mentally retarded children by the recruitment and training of professional staff and by better integration of these services into overall maternal and child health programs and

with other community facilities. Clinic teams were enlarged in order to reduce the backlog of cases awaiting diagnostic evaluation. Several States planned for the early detection and treatment of specific causes of mental retardation, such as phenylketonuria, in which prevention is possible.

Developments in the field of mental retardation throughout this period were once again proving the validity of the "team" approach in children's services.

Accidents are the chief cause of death in children aged 1-18. Since the temporary and permanent disability from accidents affects a much larger number of children than of adults, maternal and child health and crippled children's programs were devoting greater attention to educational efforts directed toward prevention of accidents, to studies of childhood accidents, and to poison control. In 1957, more than 15,000 children received physicians' services in the crippled children's program because of accident, nearly one-third of them because of burns. In at least two regions, conferences on accident prevention—sponsored by the Public Health Service in cooperation with the Children's Bureau—were held.

Adaptation of maternal and child health services to the health needs of migrants was the focus of a special migrant project in Florida during 1958. Family clinics were held during evening hours after the work was finished. Mothers and fathers were seen by a physician; at the same time a pediatrician examined the children.

Provisions for Indian children represented an area of expanded activity for a number of State maternal and child health programs. These were developed cooperatively with the Indian health services.

One unfortunate aspect of increasing numbers of hospital deliveries, of overcrowded and inadequately staffed nurseries, and of increased use of antibiotics has been the emergence of antibiotic-resistant staphylococcal infections.

The concern of maternal and child health programs in this connection has been primarily with the control of staph infections in newborn nurseries. State health departments were approaching the problem in a variety of ways, through hospital consultation and consultation with the professional disciplines concerned.

For many years, the infant mortality rate for the United States decreased steadily. But in 1957, for the first time in 20 years, an annual increase occurred in the infant mortality rate of more than 1 percent. In 1958, a further rise occurred. This break in progress in conserving infant life was of great concern to those administering maternal and child health programs. Neonatal mortality also advanced about 3 percent annually, both in 1957 and 1958, compared with 1956.

State health departments reported that the percentage of infants under age 1 in our population who were served by well-child conferences had doubled since 1945, rising from 7 percent to 14 percent. Because of the large numbers of families seeking such services for their babies, often some sacrifices in quality of care had occurred. A number of health departments were greatly disturbed that, because of clinic overcrowding, physicians could spend so little time with mother and baby.

These service problems were generally more acute in central cities, especially where the composition of the population had changed and where middle- and upper-income groups had moved to suburban counties, leaving a large proportion of lower income population levels in the city.

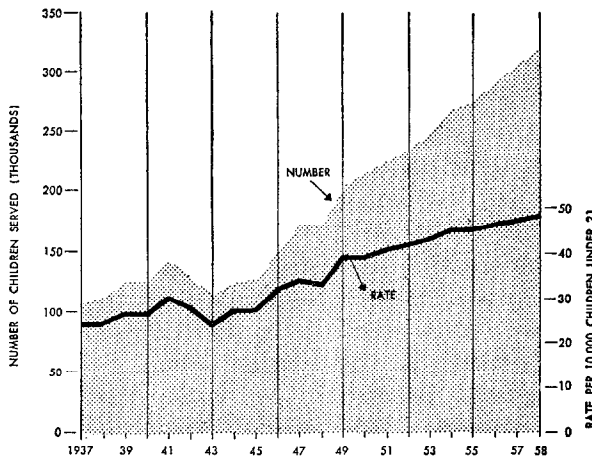
While 71 percent of the infants served in well-child conferences received these services in metropolitan counties, only an insignificant share of Federal grant-in-aid funds were distributed to cities. The problems of financing health services and medical care were becoming increasingly difficult, with a greater proportion of the population dependent on public resources for these services.

The early discharge of mothers and infants from large municipal hospitals also pointed to the need for more comprehensive supplementary community services and for services to selected mothers and their infants in their own homes, such as public health nursing follow-up and homemaker service.

On the basis of figures furnished by the States, the Children's Bureau in the fall of 1959 estimated that about 1 child in 3 in the population under age 21 had been immunized against polio through maternal and child health programs. In 1956-58, a total of 22,000,587 children under

CHART 2.—Services for crippled children under the Social Security Act, 1937–58

SERVICES FOR CRIPPLED CHILDREN ARE INCREASING



age 21 received the basic series of polio immunization through these programs.

Crippled children's services.—A new peak was reached in 1957 in the number of handicapped children served under federally aided programs. Of the 313,000 children cared for during the year, 246,000 were seen in clinics; about 66,000 received physicians' services through home or office visits. About 52,000 children were hospitalized. Convalescent home care was given to the smallest group, around 3,700.

By 1958, some 325,000 children were receiving medical service under the crippled children's program—4.8 per 1,000 of the population, or twice the rate in 1937.

Orthopedic handicaps now constitute only about 50 percent of the diagnostic conditions.

During this period (1956–60) one of the major interests of the Bureau was to help children with congenital heart disease to benefit from heart surgery.

Some 50,000 infants are born each year with some form of congenital heart disease. The vast majority of these can be given normal life expectancy through the new kinds of surgery.

The number of children with congenital heart malformations served under the program went up from 2,200 in 1950 to 12,000 in 1958. It was because of this rapid expansion that Congress granted the Bureau's request for \$1.5 million in supplemental funds to be used during 1958 and 1959 to finance the program.

In the summer of 1958, the Children's Bureau and the Prosthetics Research Board jointly sponsored a conference at the Michigan Child Amputee Center where directors of 12 major child amputee clinics in the country agreed to participate in a nationwide program for testing prostheses used for child amputees.

This testing project is being evaluated by the New York University College of Engineering, which has received a Bureau grant for its support. The project is moving ahead in an effort to get the best possible answers to such questions as the best age to fit a baby with an artificial hand, how to use a suction socket leg for children under age 12, and how best to use a preflexed arm for child amputees.

Another significant development during 1958–59 is the trend toward the establishment of diagnostic and treatment centers for children—especially for children with multiple handicaps—in outpatient departments of teaching hospitals. These centers are based in the pediatric department but available to the centers are all medical specialties—medical social work; nursing; psychology; physical, occupational, and speech therapy; and a variety of other disciplines, including special education.

Several States were beginning to develop services for children with nephrosis, cystic fibrosis, and other metabolic and degenerative diseases in which the prognosis can be materially improved through early recognition, continuous and proper medical treatment, and follow-up.

Child welfare services.—By 1960 many States had made real progress toward a well-rounded child welfare program. But no State has as yet completely achieved the goal of services in the variety and quality required to meet the needs of all children.

The services in many States still had too narrow a legal base, and the structure and organization of them in many States left much to be desired.

On June 30, 1959, more than 7,000 full-time public child welfare employees in professional positions were providing services to 364,300 children. Forty percent of these were in their own homes or in the homes of relatives, 43 percent were in foster family homes, 17 percent were in institutions or elsewhere.

The use of educational leave had grown to the point that practically every State was using Federal funds for this purpose. About 10 percent of the \$13 million allocated to States for child welfare in 1960 was used for educational leave.

The most significant amendments to Title V, part 3, were made in 1958. They lifted the restriction on the use of Federal funds to rural areas, so that funds can now be used by the States where needed. At the same time the authorization was raised to \$17 million, and Guam was brought into the program.

The 1958 amendments also brought a change in the way funds were to be allotted to the States. They also provided for the first time that Federal child welfare services funds, beginning July 1, 1960, were to be matched by the States. This matching was to be done on a variable basis related to per capita income so that poorer States receive a larger proportion of Federal funds in relation to their expenditure for child welfare.

The 1958 amendments also provided for an Advisory Council on Child Welfare Services to study the services provided under Title V, part 3, and to make a report to Congress and to the Secretary of Health, Education, and Welfare on or before January 1, 1960.

The Council appointed by the Secretary consisted of 12 persons, including representatives of public, voluntary, civic, religious, and professional welfare organizations and of the public.

During the course of its deliberations, the Council with the assistance of the staff of the

Bureau gathered information from all the State public welfare agencies and from national voluntary child welfare agencies.

Some of its recommendations to be implemented require changes in laws, some deal with the 1958 amendments to the Social Security Act, one urges Congress to expand the personnel and financial resources of the Children's Bureau so that it can more adequately discharge its functions.

The focus of child welfare services over the years has shifted from care of children away from their own homes to working with parents to prevent the breaking up of homes.

This change reflects one of the most significant trends in the child welfare field—the emphasis on the preservation and strengthening of the family—and it is a trend sweeping on into the future.

Child welfare agencies are reaching out with services to special groups of children—the mentally retarded, the emotionally disturbed, the neglected and abused, the delinquent, the children of migrant workers.

Many more children than previously are able to remain in their own homes with their own parents. Others are finding permanent homes through adoption.

Only 47 percent of the rural counties have public child welfare workers. The net effect is a major discrimination against rural children in terms of these services.

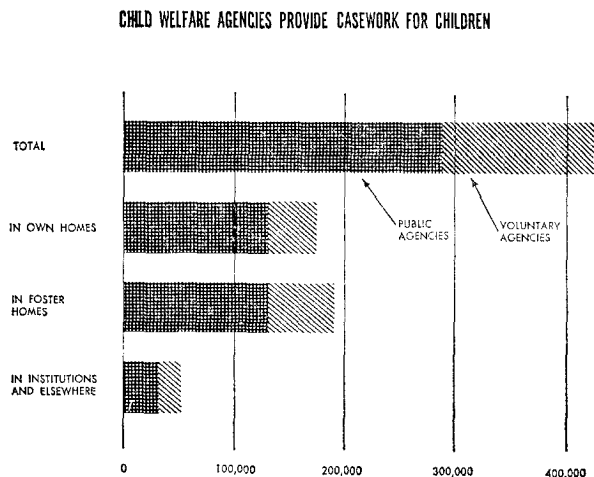
In 1957 and 1958, the Bureau concentrated on finding ways to bring doctors, lawyers, and social workers together in planning more adequate services for unmarried mothers and in identifying the respective roles of these professions in adoption placements.

Child welfare agencies are seeing more children with complex problems. On the other hand, fewer children are coming to the attention of these agencies because of problems stemming primarily from inadequate income.

More and more cases of neglect and abuse are being referred to child welfare agencies. Children appear more seriously disturbed than ever before.

THE ENTIRE STORY of the programs under Title V of the Social Security Act would take many volumes to recount. Here we have presented

CHART 3.—Children receiving child welfare casework services from public welfare agencies and from voluntary agencies, 1958



some of the highlights of the many developments in these programs.

The three programs have some things in common. In all of them, the most consistent trend has been toward broadening the services to meet the needs of special groups of children.

All three programs consistently have carried the torch for higher standards of care and services of better quality.

The three programs have reached out to hard-to-serve groups—children in isolated areas, children with special problems, children requiring specialized services.

More and more the programs have stressed the preventive aspects of their services.

All have consistently struggled to improve the quality and skills of the workers as well as their numbers. Often only the high purposes and strong will of those administering and carrying on the services have made it possible to keep services from eroding in quality.

The programs have been responsive to new knowledge, new treatment, and new facilities. They have kept their services in tune with the changing pace and circumstances in the lives of families and children in the Nation.

Twenty-five Years of Unemployment Insurance in the United States

by R. GORDON WAGENET*

INTEREST IN UNEMPLOYMENT insurance legislation in the United States first appeared long before the enactment of the Social Security Act, but it took the most severe depression in the Nation's history and the encouragement of State action through the Social Security Act before unemployment insurance became a reality throughout the land.

In 1931, when unemployment reached 8 million or 16 percent of the labor force, 52 bills for compulsory unemployment insurance were introduced in 17 State legislatures, but only in Wisconsin was an unemployment insurance law enacted (in 1932) before congressional consideration of the Social Security Act. Within 2 years after the adoption of the Social Security Act in 1935, all 50 States and the District of Columbia had approved unemployment insurance laws. By 1939, all State unemployment insurance laws were fully operative and were paying benefits to eligible unemployed workers.

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THE FEDERAL-STATE SYSTEM

The Social Security Act did not establish a system of unemployment insurance in the United States. It provided an inducement to the States to enact unemployment insurance laws. It levied a tax on the payrolls of employers of eight or more workers in commerce and industry and provided that if a State enacted an approved unemployment insurance law, subject employers could offset, against the Federal tax, contributions under the State law up to 90 percent of the Federal tax. The tax was 1 percent of payrolls in 1936, 2 percent in 1937, and 3 percent in 1938 and thereafter.¹

The Federal tax removed one of the major obstacles to State action. No longer did a State fear that its unemployment insurance law would place its employers at a competitive disadvantage with employers operating in a State without such a law.

The Federal-State partnership provided in the

¹ Since 1939 only the first \$3,000 of annual wages paid to an employee by an employer is subject to the tax.