ly by private individuals and organizations in direct payment for medical care, it is estimated that two-thirds would, in the future, be paid for by insurance premiums.

Realizing on Health Investment

Analysis of the costs of the national health program laid down in the report shows that we may reasonably expect that an annual investment of $4 billion by State, local, and Federal Governments can ultimately produce an annual return—in national wealth—of several times that amount. This is a good investment in terms of cash, and the returns to the Nation in terms of human welfare, of added national strength and vitality, are beyond dollar value.

Specific recommendations for carrying out the proposed program are spelled out in more detail in the report. The total goal—both for the individual and the Nation, since the welfare of the individual and of the Nation are one and the same thing in health—is clearly expressed in the statement of our aims for every American:

To assure for every individual his utmost degree of health—a condition in which all his physical and mental powers are functioning at their best—through providing complete health and medical services to everyone in the Nation; to do this for every man, woman, and child, without regard to his race or religion, the color of his skin, his place of national origin or the place he lives in our land, and without regard for his personal economic status.

Trends in Recipient Rates for Aid to Dependent Children

By Elizabeth T. Alling*

The article that follows discusses trends in the number of children receiving aid to dependent children since 1940 in relation to the increasing child population. It parallels the article on old-age assistance in the October Bulletin. The recipient rates shown are based on unpublished estimates of child population recently made by the Bureau of the Census. Because of revisions in the population base, the new rates are more nearly comparable from year to year than were those published periodically over the same years and based on annual estimates of child population made by the Social Security Administration.

THE NUMBER of children receiving aid to dependent children in June 1948 was 37 percent higher than in June 1940. Measured against an increase of about 12 percent in United States population under age 18, the increase shrinks to 25 percent—a change from 20 children aided per 1,000 in June 1940 to 25 children per 1,000 in June 1948. The increase in the proportion of the child population aided under this program is in sharp contrast to the slight drop during the same period in the proportion of aged population receiving old-age assistance.

Growth in Number of State Programs

One explanation of this contrast is the difference in many States in the status of the two programs in 1940. By June of that year, all 51 jurisdictions had State-Federal programs of old-age assistance, whereas nine jurisdictions [1] had not yet replaced mothers' aid or mothers' pension programs with aid to dependent children. Because most of the earlier programs were not State-wide in operation and some were in effect in only a few counties, the proportion of children aided under some of them was very low—less than 1 per 1,000 in Mississippi and Texas.

By June 1942, five more States—Connecticut, Illinois, Mississippi, South Dakota, and Texas—had State-Federal programs in operation. For the country as a whole the number and proportion of children aided in that month were near their highest points before the beginning of the rather precipitous wartime decline. Iowa and Kentucky began to operate programs with Federal participation between June 1942 and June 1944. In both States, extraordinary demands for labor postponed the normal growth in the programs until after 1945. Even with the marked postwar increase in the number of children aided, the national recipient rate rose only 2 per 1,000 children in the population from June 1942 to June 1948.

How much the States that were late in initiating the State-Federal programs affected the national trend in recipient rates is clear when the trend in the rate for 50 States is compared with that for the 42 States that had such programs as early as 1940 (chart 1). The rise in recipient rate for the 42 States from June 1940 to June 1948 was equivalent to that for the 50 States from June 1942 to June 1948—2 per 1,000 children in the population. Nevada, the only State that has not started a State-Federal program, had the only recipient rate below 12 in June 1948.

Early Limitations on Eligibility

Aid to dependent children grew more slowly than old-age assistance for other reasons. In both programs the Federal law provided for Federal participation in payments to broader age groups than were eligible under many earlier State laws. For old-age assistance, the Social Security Act when passed in 1935 permitted States to operate under age limits as high as 70 until January 1, 1940, when a 65-year limit was to become effective. In anticipation of the liberalizations in the age limit for Federal participation, most States started in advance of January 1940 to operate with the 65-year limit. However, not until the amendments of 1939, effective January 1, 1940, was the age limit for Federal participation in aid to dependent children liberalized by raising it from 15 to 17 years for children regularly attending school. When this amend-

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[1] Including Alaska, which initiated a program with Federal participation in 1945 but which is omitted from this analysis because estimates of child population are not available.

ment was passed, only five States aided children 16 years of age and over. Since the change generally required amendment of State laws, the number of children 16 or 17 years of age aided by June 1940 was small. By June 1948, however, some children of these ages were aided in all States but Alaska, Georgia, Missouri, Nebraska, and Texas.

Eligibility requirements for aid to dependent children were defined somewhat less objectively than were those for old-age assistance, and they were harder to apply. The Federal act permitted broader definition of eligibility for aid to dependent children with respect to parents' incapacity and absence from home than had prevailed in the earlier mothers' aid programs. In some States the acceptance of children for this program tended for some time to be governed by the standards of the older programs, especially if general assistance was available to aid the needy children not deemed eligible for aid to dependent children. The effect on the recipient rate of successive extensions of eligibility for aid to dependent children is illustrated in the rise in Pennsylvania's rate to June 1941 and in New York's rate from June 1945 to June 1946. Many of the children added to the aid to dependent children rolls in these and other States were transferred from general assistance rolls.

As has already been pointed out, the national recipient rate for aid to dependent children was higher and the rate for old-age assistance lower in June 1948 than in June 1940. In many States, however, the change in rates for the two programs was in the same direction. Recipient rates for both programs tended to rise in low-income States and to fall in high-income States—changes which seem to reflect more direct relationship in 1948 than in 1940 between recipient loads and the numbers of needy persons.

TABLE 1.—*Number of recipients of aid to dependent children per 1,000 population under 18 years of age by State, for June of each year 1940–48* [1]

State (ranked by 1947 per capita income)	1940	1941	1942	1943	1944	1945	1946	1947	1948
Total	20	23	23	18	15	15	18	22	25
Nevada	*8*	*8*	*7*	*6*	*4*	*3*	*2*	*3*	*2*
New York	20	19	16	12	12	13	20	25	28
North Dakota	28	31	32	26	22	20	21	23	22
Connecticut	7	*6*	9	10	9	10	13	13	13
Delaware	18	23	18	9	8	9	9	8	12
California	22	21	17	10	8	7	8	10	13
Montana	33	37	38	28	22	20	24	27	30
District of Columbia	18	17	18	13	9	9	12	19	17
Illinois	*8*	*8*	24	28	23	22	24	24	23
New Jersey	23	22	17	11	8	7	8	9	10
Rhode Island	16	19	18	16	14	16	23	30	32
Colorado	41	44	42	31	26	25	28	30	33
Wyoming	23	23	23	15	11	9	10	12	12
Maryland	36	32	26	17	13	13	18	21	25
Massachusetts	26	27	25	18	15	15	17	18	20
Ohio	14	16	15	12	10	10	11	12	13
Michigan	28	31	29	21	17	17	22	25	27
Washington	26	27	24	15	14	14	20	26	28
Pennsylvania	28	53	40	26	20	20	28	33	33
South Dakota	*19*	17	21	20	18	17	22	23	22
Wisconsin	29	30	28	20	16	14	16	18	19
Kansas	27	29	30	22	16	13	17	22	21
Idaho	39	42	42	30	22	18	21	24	26
Indiana	35	34	29	21	15	13	14	16	18
Oregon	16	17	16	10	8	8	9	14	16
Nebraska	29	33	31	22	17	14	16	19	19
Utah	40	49	41	23	21	20	23	27	31
Missouri	24	29	29	26	25	26	35	46	45
Minnesota	25	26	26	20	16	14	15	17	19
Vermont	14	15	17	16	14	13	15	16	19
New Hampshire	12	10	15	14	13	13	17	19	19
Iowa	*9*	*10*	*9*	*8*	10	10	12	14	16
Maine	14	14	19	18	15	14	16	19	25
Texas	(2)	(2)	14	12	10	10	10	14	17
Arizona	38	34	30	23	19	19	24	29	29
Florida	16	18	22	16	14	20	23	36	53
Virginia	10	13	14	12	10	10	11	12	14
New Mexico	24	25	31	30	29	31	33	41	51
West Virginia	29	33	45	33	26	28	32	36	42
Oklahoma	51	60	60	45	44	46	61	86	72
Tennessee	34	34	33	30	26	26	28	32	36
Louisiana	42	45	44	35	29	26	27	33	40
North Carolina	16	16	16	13	11	11	12	15	18
Georgia	8	10	10	9	8	8	10	36	18
Kentucky	*1*	*1*	*2*	3	11	13	15	23	33
Alabama	15	15	14	11	11	12	17	20	25
South Carolina	11	14	15	13	12	13	16	18	20
Arkansas	16	22	22	19	17	16	17	25	33
Mississippi	(3)	3	7	7	8	8	11	17	17
Hawaii [4]	24	24	16	11	10	9	11	16	23

[1] Figures in italics represent programs administered without Federal participation. Population as of July 1 of each year from unpublished estimates of the Bureau of the Census. Estimates of child population for Alaska not available.

[2] Less than 0.5 recipient per 1,000 population under 18 years.

[4] Not ranked because data on per capita income not available.

Relationship to Per Capita Income

When States are ranked according to per capita income in 1947, the median State is Oregon. This State's recipient rate for aid to dependent children was the same in both June 1940 and June 1948. Rates were higher in June 1948 in all but five of the States that ranked below Oregon in per capita income—Arizona, Louisiana, Minnesota, Nebraska, and Utah. Conversely, all but seven of the States that ranked above Oregon in per capita income aided smaller proportions of children in the later month; the seven exceptions were Connecticut, Illinois, New York, Pennsylvania, Rhode Island, South Dakota, and Washington.

The States with lower recipient rates in 1948 include industrial States in which the growing program of survivor benefits under old-age and survivors insurance provides income for a considerable number of children whose fathers have died. Also included among the States with recipient rates that were lower in 1948 than 8 years earlier are a number of predominantly rural States in which unusually high agricultural income has reduced the need for aid to dependent children.

The surviving children of insured workers who died on or after January 1, 1940, are eligible for benefits under old-age and survivors insurance. The effect on the assistance rolls was small in the early years. By June 1948, however, the total number of children re-

TABLE 2.—*Recipient rates for aid to dependent children in 12 lowest-income States according to quartile rank among all States, June 1940 and 1948*

Month and year	Lowest quartile	Third quartile	Second quartile	Highest quartile
June 1940	Georgia (8) Kentucky (1) Mississippi [1] South Carolina (11)	Alabama (15) Arkansas (16) North Carolina (16)	New Mexico (24) North Dakota (28)	Louisiana (42) Oklahoma (51) Tennessee (34)
June 1948	Mississippi (17)	Georgia (18) North Carolina (18) South Carolina (20)	Alabama (25)	Arkansas (33) Kentucky (33) Louisiana (40) New Mexico (51) Oklahoma (72) Tennessee (36) West Virginia (42)

[1] Less than 0.5 recipient per 1,000 population under 18 years.

ceiving insurance benefits—most of whom were half-orphan or orphan children—represented about 12 per 1,000 children under age 18 in the total population. In Connecticut, Delaware, New Jersey, and Ohio, more children were receiving old-age and survivors insurance than received aid to dependent children. Increase in the number of child beneficiaries cannot be expected to result in a corresponding decrease in the number of children receiving aid to dependent children, since some of the child beneficiaries are not "needy" under assistance standards, while others need assistance to supplement their small insurance benefits.

Although currently there is not a consistent relationship for all States between the proportion of children aided and the extent of need as measured by per capita income, this relationship is closer in 1948 than it was in 1940, or even in 1942. This is most apparent, happily, with respect to the lowest-income States (table 2).

In June 1940, only five of the 12 States with lowest per capita income had recipient rates above the median. In June 1948, on the other hand, eight of the lowest-income States had recipient rates above the median, and the rates of seven of these States—Arkansas, Kentucky, Louisiana, New Mexico, Oklahoma, Tennessee, and West Virginia—ranked among the highest fourth. Furthermore, in Mississippi, acceptance after June 1948 of substantial numbers of eligible children, who previously had not been receiving assistance because of inadequate assistance funds, raised the State's recipient rate to 21 in September 1948, transferring this State from the lowest to the third quartile. Nevertheless, the appearance of any of the States with lowest per capita income among the States having recipient rates below the median suggests that inadequate funds still limit the number of needy children assisted in these States.

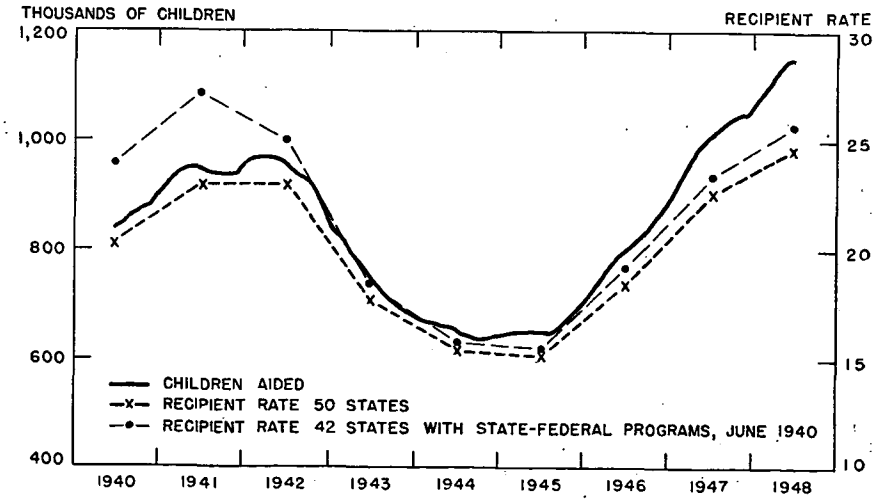
In June 1948 the 12 States with highest per capita income were spread through three quartiles of the ranking of States by recipient rates. Half of them—twice as many as in June 1940—were in the lowest quartile. Half, however, were above the median, and two—Colorado and Rhode Island—were in the highest quartile. Even in States where per capita income is high, the distribution pattern of family income may result in need for assistance for many children. High per capita wealth, however, enables States to make adequate appropriations for assistance and to set up eligibility requirements that do not bar needy persons.

Relationship to Total Child Population

The national recipient rate showed its greatest 12-month rise between June 1946 and June 1947. Both the precipitous rise in prices in 1946 and the increase in Federal funds provided by the 1946 amendments to the Social Security Act were factors. Some States had equivalent or even larger increases from June 1947 to June 1948. Other States had relatively small increases—or decreases—partly because of apprehension about the postwar growth in this program. Here again, measurement of the number of recipients against the size of the age group in the total population, and comparison between aid to dependent children and old-age assistance, are helpful.

Although the number of children receiving aid to dependent children has increased substantially, the number has always been small in relation to the total number of children in the population. In contrast to the proportion of aged persons receiving old-age assistance—not less than 20 percent throughout the period 1940–48—the proportion of children receiving aid to dependent children has remained under 3 percent. Most children, fortunately, live in families with

CHART 1.—*Monthly number of children receiving aid to dependent children and June recipient rates for 50 States and for the 42 States with State-Federal programs throughout the period June 1940–48*



both parents in the home and able, under present economic conditions, to provide for their support and care. Aid to dependent children was provided by Congress and the States for the relatively few children who live in broken families or have incapacitated parents.

The rapid postwar rise in the number of children receiving aid to dependent children represented, for the country as a whole, an increase from 1.5 percent of all children in June 1945 to 2.5 percent in June 1948. Furthermore, in only 14 States (four of them with new State-Federal programs) did the increase in recipient rate from June 1940 to June 1948 represent as much as 1 percent of all children in the State. An increase of this size in an 8-year period does not seem to justify policies which result in denial of assistance to children in actual need.

(*Continued from page 8*)

The plans also employed a fairly large number of dentists, nurses, and auxiliary personnel. In most instances, those older plans still adhere to that method of providing benefits. The plans developed since that time have shown a tendency—since most of them have been sponsored by medical societies and Blue Cross—to provide benefits through local hospitals and physicians engaged in fee-for-service practice. Members in the newer plans are permitted to select their own physicians and hospitals from among all those that have agreed to participate in the program. This provision has resulted in a tremendous increase in the number of physicians associated with voluntary medical care plans, has given them an opportunity to gain personal experience with prepaid medical care, and has assured them payment for services provided.

While the number of physicians associated with prepayment plans has thus increased, there has been little change in the number of dental and nursing personnel. With few exceptions, the dentists and nurses connected with prepayment plans are associated with plans that were in operation before 1945. Although the cost of dental and nursing services represents a significant portion of family expenditures for medical care, few of the most recently established plans include such services among benefits provided; separate dental and nursing prepayment plans are almost unknown.

Future of Prepayment Plans

The fact that some type of prepayment for medical care is desirable seems to be well accepted by all groups concerned. What type of program or programs will be developed in the future will depend in large measure on the cooperative efforts of persons and organizations interested in all phases of medical care. An editorial in the *Weekly Bulletin of the St. Louis Medical Society* (October 1, 1948) states, "The issue now is not whether we should or should not have prepayment medicine, or budgeted medicine, or collective medicine or whatever else one wishes to call it, but what kind of prepayment medicine shall we have and who is to control it. If a plan can be worked out in which there is free choice of physician, there is reasonably adequate coverage, and in which the major issues are decided by the doctors and patients immediately involved, no harm can come to the spiritual or material development of medicine."

A recent issue of the *Journal of the American Medical Association* contains a report by the Association's Council on Medical Service that points the way toward better understanding among proponents of various types of plans in the future. Two statements in the report are of particular interest: (1) that proposed changes in the standards of acceptance that the Council developed as a guide to evaluating prepayment medical care plans are under consideration, and (2) that the application of the principle of free choice of physician and hospital as it applies to prepayment plans is not yet entirely clear to the Council, and the extent to which free choice of physician may possibly be limited in various plans has been reviewed and will be discussed further with the Judicial Council.[23]

The National Health Assembly held in Washington in May 1948 at the invitation of Oscar R. Ewing, Federal Security Administrator, frankly recognized prepayment as a principal factor in medical economics. The following "Principles for the Improvement of Voluntary Prepayment Plans," unanimously accepted by the Medical Care Section of the Assembly, indicate the desire of the various groups represented to effect practical consumer and professional cooperation in the development of such plans.[24]

"1. There should be the freest opportunity for full cooperation among the providers and consumers of service in the establishment and the administration of medical care plans, provided that full control of the practice of medicine in the program must remain with doctors.

"2. The Medical Care Section strongly urges the importance of joint conferences at the earliest possible date among representatives of the American Medical Association and of groups representing the consumers of medical care and services to study the question of the establishment and administration of medical care plans."

[23] "Report of the Council on Medical Services," *Journal of the American Medical Association*, May 8, 1948, pp. 193–198.

[24] Oscar R. Ewing, *The Nation's Health—A Ten Year Program*, September 1948, p. 76. For a summary of one section of the report see this issue of the *Bulletin*, pp. 9–12.

(*Continued from page 2*)

The survey's primary purpose is described by Ernest V. Hollis, who is directing it, as the development of a "well-grounded body of principles which is sufficiently inclusive to enable social work educators to reexamine and extend programs of study and development along lines which promise to supply the quantity and quality of social workers that are likely to be needed in the United States and Canada."

Mr. Hollis is taking leave of absence from the Office of Education to serve as director of the study; the assistant director is Alice L. Taylor, of the Social Security Administration. Arthur J. Altmeyer, Commissioner for Social Security, is a member of the national advisory committee.