Report on the Nation's Health

The Federal Security Administrator, Oscar R. Ewing, submitted on September 2 the study requested by the President on "possibilities for raising health levels and on feasible goals that might be realized by the American people in the next decade." The report, which draws heavily on the findings and recommendations made last May by the National Health Assembly, itemizes the debits and credits to our national health, noting the great achievements made by medical science over the past few years and calling attention to the possibilities still unrealized because of the limited availability of medical services.

THE CENTRAL PURPOSE of the program set forth in the report, *The Nation's Health—A Ten Year Program*,[1] is "to promote the highest possible level of national health." To this end the report assesses our health and medical resources—the manpower, facilities, knowledge, and funds used for promoting health; considers the economics of health and medical services; states the 10-year health goals proposed; and outlines programs that will enable the Nation to meet those goals. The first chapter, The Health of the Nation, sums up the material in the body of the report; a summary of this chapter follows.

The Health of the Nation

During the last generation the United States has steadily improved its health record. Years have been added to the average life expectancy at birth, certain disastrous epidemics have been virtually eliminated as a threat to health, and many diseases high on the mortality lists of the past have been sharply reduced.

Good as the record is, plenty of room for improvement remains; the Nation and its people still suffer severe losses through sickness, disability, and death—much of which is unnecessary. Every year, some 325,000 people die whom we have the knowledge and skill to save. Every year the Nation loses about 4.3 million man-years of work, approximately $27 billion in national wealth, through sickness and disability.

The problem is both national and individual. For the Nation, prosperity and the national security depend heavily on maintaining health at the highest possible levels. For the individual, no one has the equality of economic opportunity that is the tradition of our American democracy if, through being unable to obtain the health or medical services he needs, he suffers ill health or disability.

Conclusions on Key Health Problems

Manpower.—Our health manpower—physicians, dentists, nurses, and supporting personnel—is insufficient in numbers and so poorly distributed that large sections of the country and many millions of people are without even minimum health and medical services. We have only 80 percent as many physicians as we need and even greater shortages of other medical personnel.

Moreover, we do not have enough medical colleges, training schools, and teaching hospitals to close the gaps between need and supply at any time in the foreseeable future. The financial condition of most training institutions is such that they have great difficulty in maintaining standards of quality and, without help, can rarely even consider increasing their production of needed manpower.

Hospitals.—Our hospitals and other health facilities have not kept pace with our needs. We have only about 50 percent as many acceptable hospital beds as we require. Only through the recently enacted Federal Hospital Survey and Construction Act has there been any Nation-wide effort to plan construction on a State or a regional basis. For the most part, hospitals have been planned, constructed, and operated without reference to the economic and efficient provision of the wide variety of services expected in modern institutions. They operate mostly as independent units, without reference to one another, without arrangements to provide their patients, through integration with other institutions, the services which they individually lack.

Local organization.—The Nation's health resources are not used at full efficiency. Public and private services alike have for the most part grown up without effective plans. Some 18,000 local political units provide some form of health and medical services. About 20,000 voluntary health organizations and some 6,000 hospitals are operating in different communities, each segment generally independent of the rest. The lack of organization in many communities throughout the country makes it impossible for them, and for many of their citizens, to obtain even those services that are available in their regions. There are grave shortages in such fundamental provisions as local public health departments; where these departments exist, they are largely understaffed and underfinanced.

Research.—Our search for new knowledge about man and his human need is feeble compared with our search for knowledge that will contribute to material wealth. Nationally, we spend more than $1 billion on all types of research; only a little more than 10 percent is devoted to medical and related sciences.

Individual cost of care.—Perhaps the basic lack of our entire health effort is the absence of any method that would permit the individual, regardless of the level of his personal income, to obtain the kind of services he needs to achieve better health.

A scant 20 percent of our people are able to afford all the medical care they need. About half our families—those with incomes of $3,000 or less—find it hard, if not impossible, to pay for even routine medical care. Another 30 percent of American families with incomes between $3,000 and $5,000 would have to make great sacrifices or go into debt to meet the costs of a severe or chronic illness.

For the community, this lack of purchasing power helps to limit the number of doctors and other person-

[1] *The Nation's Health—A Ten Year Program: A Report to the President* by Oscar R. Ewing, Federal Security Administrator. U. S. Government Printing Office, September 1948, 186 pp. (Available from the Superintendent of Documents, U. S. Government Printing Office, $1 a copy.)

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nel who will practice there. Equally, it places high barriers in the path of building up adequate health facilities.

Basic Goals for the Health Program

The emerging pattern of community-State-Federal cooperation for improved health provides the framework in which the following basic goals of the national program are drawn up.

Manpower.—To increase sharply our total professional manpower through training programs and through financial and other support; to expand medical colleges, training schools, and teaching hospitals and establish new ones until, by 1960, our annual production of medical manpower in all categories has increased by 40 to 50 percent.

Hospitals.—To double the number of acceptable hospital beds as rapidly as possible, certainly within 15 years, and at the least by 1960, to have added 600,000 beds to our hospitals and built such additional health centers and auxiliary facilities as State-by-State surveys have shown to be necessary throughout the country.

Local organization.—To provide Federal assistance by counsel, demonstration, and other means for the establishment of citizen health councils in every State and community, and to provide Federal assistance in establishing and maintaining adequate local health units everywhere; and to assist in increasing and improving the training of public health workers to the end that their numbers shall be doubled.

Individual costs.—To provide that all people shall have access to such health and medical services as they require through a system of insurance covering the entire population.

Research.—To increase our investment in medical and related research as rapidly as scientists can be trained until total national research is adequate to keep pace with our expanding needs. By 1960, Federal nonmilitary research should reach a total of $80 million to $100 million if enough qualified scientists are available.

Special Programs To Promote Health

Our basic health needs will be met if we reach the goals already set forth. No effort to raise the levels of national health will be complete, however, without special effort in certain areas of increasing importance. Following are the goals in these areas:

Mental health.—To focus attention on mental health as a leading area for medical progress in the last half of this century; to promote research in the field of psychiatry and in the mental-emotional aspects of physical illness; and to expand manpower and facilities for both preventive and curative work throughout the country.

Healthy maturity.—To enable everyone to enjoy a healthy, active, and productive maturity, by controlling chronic disease—the greatest single barrier to achievement of this goal—and by relieving other physical and mental problems of adult life.

Rehabilitation.—To provide rehabilitation services for the 250,000 men and women who become disabled through illness or injury every year so that they can be restored to the most nearly normal life and work of which they are individually capable.

Maternal and child health.—To assure to every child in the country the utmost degree of health, a condition in which all his physical and mental powers are functioning at their best; to do this through a national plan that will build progressively toward complete medical care and social, psychological, and health services for all children and for mothers in childbirth, wherever they live and whatever their race or income.

Other programs.—Our program for national health must also lay special stress on fields in which progress has been great, but in which extra effort can still pay large rewards. Accident prevention is one of these fields; the others include sanitation, control of venereal disease and tuberculosis, and better nutrition.

Financing the Health Program

This expansion of health and medical services will, of course, cost more money than is now spent, but before the details of this increased expenditure are estimated, we should examine what ill health costs the Nation in actual dollars and cents.

The value of all goods and services, including wages and salaries paid, last year amounted to $230 billion. About 60 million workers were employed, so each one produced an average of about $3,800. By applying this figure to days absent from work because of illness and disability, we can get a rough idea of the national loss.

Short-term sickness—sickness or injury that lasts 1 day to 6 months—resulted during 1947 in an average loss of 6 days per worker. At 1947 rates of production, this type of sickness cost the Nation at least $5 billion in lost production and wages. Long-term sickness or injury that keeps a worker away from his job 6 months or longer affected some 3 million workers and resulted in a national loss of $11 billion. The cost to the Nation of partial disability, which prevents people from working and earning at full capacity, is conservatively estimated at $11 billion. The Nation thus lost during 1947 a total of $27 billion in potential production and wages through sickness and disability. In addition, an estimated $11 billion was lost because of premature deaths—deaths occurring before age 65, which is generally recognized as retirement age—from preventable causes.

Against these losses from sickness and disability, which last year amounted to more than 10 percent of our national product, the Nation as a whole spent from public and private funds a trifle more than 3 percent, or approximately $8.5 billion, for medical and health services. Of this amount, the local, State, and Federal Governments spent almost $2 billion for medical care and preventive services (table 1), and private individuals and organizations spent the rest, $6.5 billion.

From a purely financial angle, investment in the greatest of all our resources—the health of the people—is at least as profitable as conservation of our natural resources has proved to be in the past, even if we ignore the relief of human suffering and the preservation of lives that an expanded health program will bring.

To make a beginning on reducing these human and material losses, a gradual expansion of health services and resources is proposed. This expansion will involve both an increase in spending—impossible to estimate exactly—by local, State, and Federal Governments and the institution of

TABLE 1.—*Government expenditures for civilian health, 1947*

	Federal	State and local	Total
Medical care of the needy (noninstitutional)	$25,000,000	$125,000,000	$150,000,000
Community health protection	69,000,000	247,000,000	316,000,000
Rehabilitation	18,000,000	7,000,000	25,000,000
Hospitals:			
Authorized construction	77,000,000	150,000,000	227,000,000
Maintenance of hospitals for tuberculous, mental, and chronic patients		373,000,000	373,000,000
Maintenance of general hospitals		300,000,000	300,000,000
Maintenance of Federal establishments, including veterans' medical care	534,000,000		534,000,000
Health manpower (training)	(*)	15,000,000	15,000,000
Research	20,000,000	2,000,000	22,000,000
Total	$743,000,000	$1,219,000,000	$1,962,000,000

* Less than $1,000,000.

a prepaid system of Government insurance. Table 2 shows the estimated expenditures, exclusive of Federal contributions to Government health insurance, that governments would be making for civilian health by 1960 under the program laid down in this report.

The extent to which a system of national health insurance will reduce certain categories of direct governmental expenditure cannot be accurately calculated, but certain costs would be cut sharply. The reduced expenditure for medical care for the needy, shown in table 2, is based on the assumption that welfare agencies would pay into the insurance fund the premiums for the needy at the average per capita rate. Other reductions would depend on the extent to which insurance funds help to support medical and other training schools and research. Much would depend also on the amount of improvement in the general health through expanded health and medical resources and services and the greater access to their help that would be afforded people through a system of Government health insurance.

The various programs considered in the outline of costs, and the expenditure involved, are briefly discussed in the paragraphs that follow.

Community programs.—A well-rounded public health service is necessary in every community. In addition, further State-Federal expenditures will be needed for tuberculosis and venereal disease control, industrial hygiene, mental hygiene, maternal and child health and crippled children programs; for new programs in the fields of dental care, diabetes, nutrition, heart disease, arthritis, rheumatism, accident prevention, and medical care of migratory farm workers. These items would increase the present grant programs for health to $840 million a year. State-Federal financing should also include $310 million annually for grants and loans for the abatement of water pollution and $100 million for special grants and loans for rural sanitation facilities.

Hospitals.—Increased hospital construction and the recommended changes in the matching would indicate an annual Federal, State, and local outlay of $485 million for hospital construction, of which the Federal share would be between $200 million and $240 million. Federal grants-in-aid to the States for the maintenance of general hospitals and tuberculosis and mental hospitals, and for the hospitalization of other chronic disease patients, should provide 40 percent of maintenance cost. A Government system of health insurance would eliminate most of the need for subsidies to general hospitals by 1960, but some will remain necessary. Health insurance will also absorb most of the present State and local expenditures for general hospital care. The remaining costs to States and localities probably would not total more than $30 million—about 10 percent of the present $300 million costs. If the hospital construction program is successful in expanding its facilities by 1960 to include 100,000 tuberculosis beds, 880,000 mental beds, and special assistance to help finance hospitalization of chronic patients, the outlay for maintenance of these types of hospitals by all governments in 1960 would amount to slightly more than $1 billion.

Other programs.—It is hoped that enough research manpower will be available in 1960 to justify a Federal nonmilitary outlay of $80 million to $100 million. No estimate has been included for State appropriations for medical research, and expenditures by the armed services are not included.

The annual State-Federal outlay for training of medical manpower should approximate $135 million by 1960, of which the Federal share would be $90 million. This sum would provide Federal assistance to schools of medicine, dentistry, nursing, and public health for defraying the cost of annual maintenance, estimated at $60 million. It would provide for construction outlays of $10 million and grants of $12 million worth of scholarships to 10 percent of the undergraduate student body and for graduate fellowships.

Government expenditures for civilian health on this basis would represent about 1.6 percent of a total personal income of $250 billion—a reasonable expectation for 1960—and would still constitute a negligible proportion of the amount the Nation loses every year through ill health. Of the $6.5 billion now spent annual-

TABLE 2.—*Estimated government expenditures for civilian health, 1960**

	Federal	State and local	Total
General medical care for the needy	$40,000,000	$40,000,000	$80,000,000
Community health protection	570,000,000	680,000,000	1,250,000,000
Rehabilitation	70,000,000	30,000,000	100,000,000
Hospitals:			
Construction grant program	210,000,000	275,000,000	485,000,000
Maintenance of hospitals for tuberculous, mental, and chronic patients	335,000,000	695,000,000	1,030,000,000
Maintenance of general hospitals	25,000,000	30,000,000	55,000,000
Maintenance of Federal establishments, including veterans' medical care	900,000,000		900,000,000
Health manpower (training)	82,000,000	45,000,000	127,000,000
Research	80,000,000		80,000,000
Total	$2,312,000,000	$1,795,000,000	$4,107,000,000

*Exclusive of Government health insurance

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.