new to their jobs within the year and their educational qualifications were slightly lower than those of the workers who had left. With only 15 percent of the jobs paying as much as $3,000-$4,000 in 1950, public assistance agencies have difficulty in competing for the limited supply of trained social workers or in inducing young people to seek such training.

Contribution to Family Life

The public assistance programs contribute greatly to the stability of the American family. Public assistance makes it possible for the needy aged, blind, or disabled person to be maintained in his own home without interruption of his family life. Aid to dependent children helps keep together parent and child and provides the opportunity for children to grow up in the setting of their own family relationships. Efforts toward rehabilitation of the needy disabled will help some of them to return to self-sufficiency; some will be able to resume responsibility for the care and for the support of their families.

Perhaps most important of all is the contribution of public assistance to the morale of the family. The basic economic underpinning has enabled the family to preserve, in the face of adversity, the continuity of cherished social values and ideals. Preservation of the family, under the strains of modern life, presents an important challenge to the knowledge and skill of the many men and women who are working to realize the purposes of public assistance.

Twenty Years of Progress for Children

by MARTHA M. ELIOT*

The Starting Point

THE dark, grim days of the depression were taking their toll in the well-being of children. Many children were not getting the health services or medical care they needed because of financial distress of the family or community. Many children were undernourished. State and local maternal and child health services and medical and hospital care and services for crippled children were being curtailed. Adolescents, unable to meet the problems arising from unemployment and depleted family resources, roamed the country. Destitute and neglected children were going without needed care and protection as a result of the reduction in State and local appropriations and voluntary contributions for child care services. In some communities, agencies had lists of children living in their own homes under conditions of serious neglect for whom foster care was not available.

Obviously, planning for the well-being of the Nation's people had to take into account the protection of the health and welfare of children. The Committee on Economic Security, established by Executive order of the President on June 29, 1934, asked the Children's Bureau to act in a consultative capacity with regard to parts of the proposed program relating to child health and child welfare. The Committee's advisory committee on child welfare worked with the Children's Bureau in developing the recommendations that the Committee submitted to the President and that he, in turn, submitted to Congress on January 17, 1935. The Committee said:

> Local services for the protection and care of dependent and physically and mentally handicapped children are generally available in large urban centers, but in less populous areas they are extremely limited or even nonexistent. One-fourth of the States only made provisions on a Statewide basis for county child-welfare boards or similar agencies, and in many of these States the services are still inadequate. With the further depletion of resources during the depression there has been much suffering among many children because the services they need have been curtailed or even stopped. . . .
>
> The fact that the maternal mortality rate in this country is much higher than that of nearly all other progressive countries suggests the great need for Federal participation in a Nationwide maternal and child-health program. From 1922 to 1929 all but three States participated in the successful operation of such a program. Federal funds were then withdrawn, and as a consequence State appropriations were materially reduced. Twenty-three States now either have no special funds for maternal and child health or appropriate for this purpose $10,000 or less. In the meantime the need has become increasingly acute.
>
> Crippled children and those suffering from chronic disease such as heart disease and tuberculosis constitute a regiment of whose needs the country became acutely conscious only after the now abandoned child- and maternal-health program was inaugurated. In more than half the States some State and local funds are now being devoted to the care of crippled children. This care includes diagnostic clinics, hospitalization, and convalescent treatment. But in nearly half the States nothing at all is now being done for these children, and in many the appropriations are so small as to take care of a negligible number of children. Since hundreds of thousands of children need this care the situation is not only tragic but dangerous.

The recommendations of the Committee for legislation relating to children were in the main incorporated in the Social Security Act, approved by the President on August 14, 1935. The act provides a dual approach to the needs of children. Title IV provides grants to States for financial aid to children deprived of parental support or care to enable them to remain with their family in their own homes. (The program is dis-

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cussed in another article in this issue.) Title V authorized grants to States for three types of specialized health and welfare services for children:

Maternal and child health services.—Part 1 authorized an annual appropriation of $3,800,000 for grants to the States to enable each State to extend and improve, as far as practicable under the conditions in such States, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.

Services for crippled children.—Part 2 authorized an annual appropriation of $2,850,000 for grants to the States to enable each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling.

Child welfare services.—Part 3 authorized an annual appropriation of $1,500,000 to enable the States to establish, extend, and strengthen, 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. The funds were to be used for local child welfare services in areas predominantly rural, and for developing State services for the encouragement and assistance of adequate methods of community child welfare organization in areas predominantly rural and other areas of special need.

An appropriation act, approved February 11, 1936, made available the following amounts for grants to States under title V for the last 5 months of the fiscal year ended June 30, 1936:

Maternal and child health services	$1,580,000
Services for crippled children	1,187,000
Child welfare services	625,000

This step, then, marked the beginning of Federal-State cooperation in the development of maternal and child health, crippled children's, and child welfare services. The cooperation of the Federal and State governments in these programs is now in its twentieth year.

Legislative Changes

Title V of the Social Security Act was amended in 1939, 1946, and in 1950. Each of these amendments increased the annual appropriation authorized for each of the three programs, as shown in the following tabulation:

Program	1939	1946	1950
Maternal and child health	$5,820,000	$11,000,000	$16,500,000
Crippled children	3,870,000	7,500,000	15,000,000
Child welfare	1,510,000	3,500,000	10,000,000

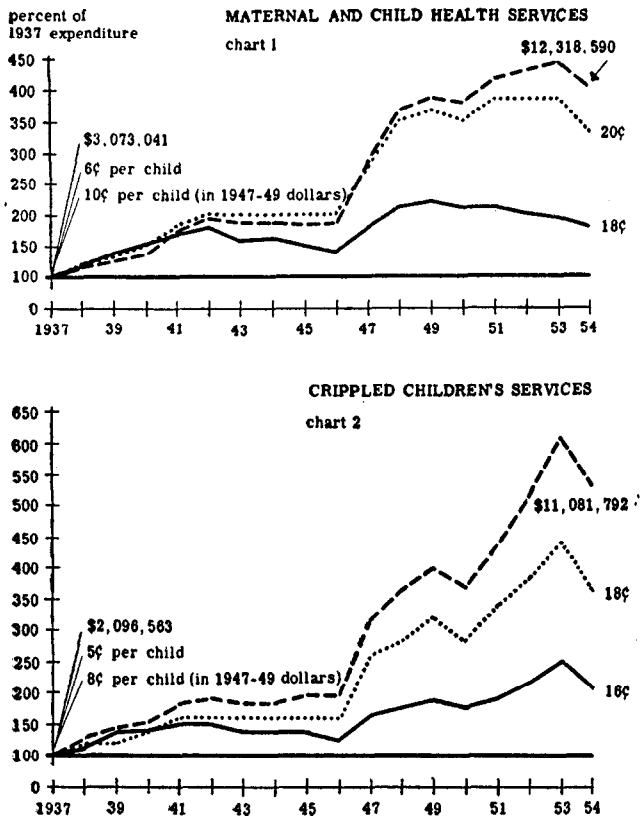
In 1943, there was established under the general purposes of part 1 of title V, through congressional appropriation, the emergency maternity and infant care program. Under this program, the Children's Bureau made grants to the State health departments to provide maternity care for wives of enlisted men in the four lowest pay grades of the Armed Forces and of aviation cadets, and to provide medical, nursing, and hospital care for their infants during the first year of life. Care provided was without cost to the serviceman's family. This was a medical care program of major proportions, in which about 1.5 million mothers and children received care, at an expenditure of more than $125 million in Federal funds, from the program's inception through its liquidation in 1949.

From the beginning, the 48 States, the District of Columbia, Alaska, and Hawaii were eligible for grants under the three programs. The 1939 amendments extended the grants to Puerto Rico, effective January 1, 1940. Under the 1946 amendments, the Virgin Islands became eligible on January 1, 1947.

The increase authorized under the 1939 amendments for crippled children's services made available for the first time a fund for services for crippled children, commonly referred to as the "B fund," to be paid to the States without matching requirements. This was the same as a fund provided from the beginning in the maternal and child health program under section 502(b) of part 1 of title V. Congress had set up this unmatched fund for allotment on the basis of the financial need of each State for assistance in carrying out its State plan. The success of the demonstration and training projects under this part of the program had already been so great that it was clear in 1939 that a comparable provision for the crippled children's program would likewise increase the benefits to these children. Furthermore, the funds that had been available on a matching basis were not sufficient to take care of children known to be in need because of orthopedic conditions and did not provide for children crippled from heart disease and other conditions. The additional sums authorized were to provide for children on waiting lists for hospital care, to make a beginning in providing care for children with heart disease, and to meet emergency conditions, such as infantile paralysis epidemics. Special demonstration projects were also started as soon as these funds were available and have proved to be of great benefit in the initiation and support of new types of work.

The 1939 amendments also added to the maternal and child health and crippled children's provisions of the act a new condition of plan approval—that the State plan provide for personnel standards on a merit basis.

The 1950 amendments specifically authorized the use of Federal child welfare funds, under part 3 of title V, for paying the cost of returning any runaway child under age 16 to his own community in another State if such return is in the interest of the child and the cost thereof cannot otherwise be met. The following proviso was also added to part 3: "Provided, That in developing such (child welfare) 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." The Conference Report of the two Houses of Congress stated in relation to this proviso



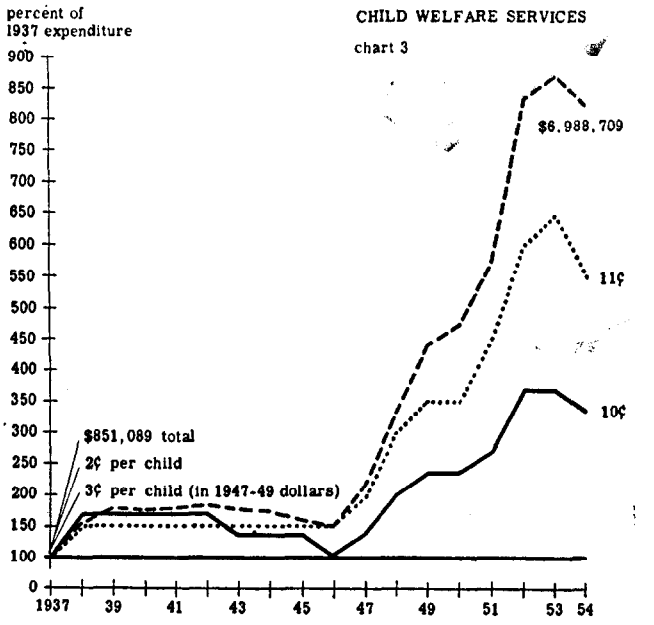


Chart 1, 2, and 3.—*Expenditures of Federal grants-in-aid to States for the development of child health and welfare services, especially in rural areas, represented in actual dollars* (broken lines); *in cents per child in the total population* (dotted lines); *in cents per child in the total population, and in cents of constant purchasing power* (solid lines).

that "the States would be free but not compelled to utilize the facilities and experience of voluntary agencies for the care of children in accordance with State and community programs and arrangements."

Program Developments

During the past 20 years, States and localities have multiplied and broadened their activities in all three programs—maternal and child health, crippled children's, and child welfare services. They have improved their administrative structure, their services in local communities, and the quality of staff providing these services. Within the past 2 decades, emphases in all three programs have been influenced by the changing times, by scientific discoveries resulting in new methods of prevention, treatment, and care, and by developing concepts in professional thought. Citizen support of all three programs has steadily increased.

A major contribution of all three programs has been the extension and improvement of training programs of personnel. From the first year in which Federal funds for the three programs became available up to the present, States have used a substantial portion of these funds to provide training, including professional education as well as in-service training. Assistance has been given to universities, schools of public health, medical schools, and schools of social work to enable them to expand and improve training for child health and child welfare personnel. During the past 2 decades, thousands of workers have received professional training as a result of the emphasis given by the States to the importance of developing and maintaining qualified personnel in these three programs.

Before considering program developments in each of the three programs, certain major factors common to all three may be summarized:

1. The design of each program is created by the States, which originate the plans submitted to the Children's Bureau.

2. Each program places responsibility for making and carrying out the State plan in a single State agency.

3. All three programs encourage local participation in the development of services for children and focus attention on the total well-being of each child.

4. All three programs place major emphasis on the employment and training of professional personnel.

5. Each program has used demonstration projects to show what States and localities can accomplish to raise the quality of care given children.

6. All three programs stress the importance of close cooperation between public agencies and voluntary organizations with similar interests.

7. All three programs have sought and received continuing support of many professional, civic, church, and other groups and organizations devoted to the well-being of children.

Maternal and Child Health Services

The program of maternal and child health services, for which Federal funds are available, is in operation in all the States, the District of Columbia, Alaska, Hawaii, Puerto Rico, and the Virgin Islands.

As the programs got under way, State health agencies gradually developed and expanded their services, including medical, dental, nursing, and nutrition services for mothers, infants, and preschool and school children.

Throughout the years, these services have been primarily "preventive" in nature. They have included prenatal and postpartum clinics for maternity patients; child health conferences for infants and preschool children; health examinations of school children; immunizations for children against diphtheria and smallpox; dental inspections; public health nursing services in the home and in clinics; and nursing supervision of midwives.

More recently States have added to their preventive health work provision for medical and hospital care of certain mothers and children. Thus sixteen States are purchasing medical and hospital care for premature infants, usually on a demonstration basis; some of the States provide medical and hospital care for mothers with complications of pregnancy; others provide dental treatment in addition to prophylaxis; and a few have established pediatric clinics on a demonstration basis.

During the calendar year 1954, preliminary estimates from State reports show that, under regular continuing programs administered or supervised by the State health agencies, 190,000 mothers attended prenatal clinics, and 432,000 infants and 569,000 preschool children attended well-child conferences, representing a total of about 2.8 million visits. There were also almost 4.4 million nursing visits for mothers, infants, and preschool children. In addition, there were about 2.6 million examinations of school children and almost 2.9 million dental inspections of preschool and school children. About 4.1 million immunizations against diphtheria and smallpox were given.

Maternal mortality has decreased to levels not considered possible 2 decades ago. Between 1935 and 1954, maternal mortality was reduced 91 percent, and infant mortality 52 percent. These reductions are the result of many factors, including the cumulative work of scientific research workers, educators, and the public health and medical professions. Undoubtedly, they reflect in part the focusing of attention on the gaps in the program and the greater availability of health and medical services made possible by the maternal and child health program authorized under title V of the Social Security Act.

The reduction in the mortality of infants in their first 28 days of life has been slower and relatively small. The leading cause of neonatal mortality now is associated with premature birth. One of the principal developments in the maternal and child health programs during these 20 years has been the increase in demonstration programs and other activities in behalf of prematurely born infants. Special grants of Federal maternal and child health funds have made it possible for some States to develop community programs for the care of premature infants, utilizing special centers in selected hospitals. Much has been learned about the care of premature infants. Much has yet to be done to prevent premature birth and put into practice what is now known to save the lives of these infants.

State and local funds for maternal and child health services have steadily increased. In 1940, total anticipated expenditures for maternal and child health services were $11.7 million. Of this amount, $6.1 million was from State and local funds and $5.6 million from Federal funds. By 1954, the total amount of such planned expenditures had increased to $52.5 million, of which $40.5 million was derived from State and local funds and $12.0 million from Federal funds.

Services for Crippled Children

All 53 States and Territories, with the exception of Arizona, are participating in the program of crippled children's services for which Federal funds are available. The programs of care are administered by the State health department in 33 States and Territories, by the State welfare department in eight States, by a combined State health and welfare department in two States, by a crippled children's commission in four States, by the State department of education in three states, and by the State medical school in three states.

In providing services for crippled children, State agencies hold crippled children's clinics at varying intervals in different parts of the State. The physicians are specialists, who make examinations and give treatment in these clinics, in hospitals, and in convalescent homes. They are paid by the State agency on a part-time salary or fee basis. Hospital care is purchased on the basis of average daily cost per patient. In many programs a pediatrician participates with the orthopedist. Working with physicians are public health nurses, medical social workers, physical therapists, nutritionists, and other therapists as needed.

Many States started their programs for crippled children with provisions for diagnosis and hospitalization only. Now many are including convalescent and foster-home care and nursing follow-up in the home.

The definition of crippling is decided by each State, either by statute or administratively. Within that definition, the State agency responsible for the crippled children's program indicates the types of crippling conditions it accepts for care. Initially, these crippling conditions were mostly orthopedic. Since 1939, however, there has been a steady increase in the number of children with other handicaps included in the State services.

At present all State programs include children under age 21 who have a handicap of an orthopedic nature or who require plastic surgery. Over half the States have developed services for children with rheumatic fever. All States provide some services for children with cerebral palsy. Some include children who are hard-of-hearing and children with epilepsy. Many States include children who have eye conditions that can be helped by surgery. The orthopedic programs provided by States are Statewide (except for the major cities, where services are otherwise available). The other types of care usually have limited geographic coverage.

Preliminary estimates based on reports from the States show that more children received care during the cal-

endar year 1954 than in any previous year. Unduplicated counts of children under care show that 265,000 children were provided physician's services in 1954 compared with 252,000 the previous year. The conditions for which these children received care include the following: congenital malformations, conditions of bones and organs of movement, poliomyelitis, cerebral palsy, ear conditions, burns and accidents, rheumatic fever, eye conditions, epilepsy and other diseases of the nervous system, tuberculosis of the bones and joints, and birth injuries.

The special projects made possible through the "B fund" grants enabled many States to initiate and extend programs to provide diagnostic services and medical, hospital, and convalescent care for children with rheumatic fever and rheumatic heart disease. The first such grant was made in 1939, and at present more than half the States have rheumatic fever programs. Special Federal grants for this purpose are now being withdrawn, and the States are taking over the programs with State and regularly apportioned Federal funds.

State and local funds for services for crippled children have steadily increased. At the beginning of the fiscal year 1939–40, the States reported that their anticipated expenditures for the year were $9.3 million. Of this amount, $5.6 million was from State and local funds and $3.7 million from Federal funds. By 1954, total anticipated expenditures had increased to $40.5 million, of which $29.8 million was from State and local funds and $10.7 million from Federal funds.

Child Welfare Services

Child welfare services for which Federal funds are available are in operation in all 53 States and Territories.

When the Social Security Act was passed, the existing local services for children living in rural areas were for the most part limited to juvenile court procedures, relief, mothers' aid programs, and foster care, either in foster family homes or in institutions. From the beginning of the grants for child welfare services under the Social Security Act, the State public welfare agencies have recognized the importance of providing for a broad variety of social services through their child welfare programs. Instead of limiting their activities to treatment after a child's own home had failed him and provision for him must be made elsewhere, the States have attempted to develop services to help children before tragedies occur, and to cooperate with other individuals and groups in developing community resources that would help to prevent dependency, neglect, and delinquency.

When a child in his own home is having difficulty in making adjustments to his home, school, or community living, the child welfare worker tries to find the cause of the problem and to help him and his parents in solving it. These workers also aid children who are neglected or abused. They arrange, when necessary, for the care of children in foster family homes and in institutions. They assist unmarried mothers, many of whom are adolescents, with their problems, and in making plans for the care of their babies. They place for adoption children who must be permanently separated from their own homes. They help to make day-care plans for children of working mothers.

In 1954 more children were receiving child welfare services from public welfare agencies than in any previous year. As of December 31, 1954, 277,000 children were receiving such services. Of these, 41 percent were living in their own homes, 42 percent in foster family homes, and 17 percent in institutions or elsewhere.

In developing their child welfare programs, States have emphasized extending geographic coverage of services of full-time public child welfare workers to areas that otherwise would have none. On June 30, 1954, 3,751 such workers were giving service to children in 1,711 (54 percent) of the 3,187 counties in the United States. This figure represents an increase of 38 percent over the total number of counties served by such workers in 1946, with the increase much greater in rural counties than in urban counties. About 75 percent of the Nation's children lived in these 1,711 counties, and only 25 percent in the counties not yet covered.

One of the most significant developments in the child welfare program during the past 20 years has been the increase in the number of children provided with foster family care by public and voluntary agencies. This number has increased 62 percent since 1933. During the same period the child population as a whole has increased only 14 percent. Children in foster family homes under public agency care increased from 49,000 in 1933 to 114,000 in 1952, and children in foster family homes under voluntary agency care increased from 54,000 to 56,000. At the same time, the number of children receiving institutional care was dropping sharply. Large custodial institutions for the care of dependent and neglected children have been used less and foster family care more. Many States and communities are also placing greater emphasis on small institutional programs for special groups of children, such as physically, mentally, and emotionally handicapped children and children in need of emergency care for short periods.

About $121 million was spent by State and local public welfare agencies for child welfare services, including the support of children in foster care, in 1953. This money came from Federal, State, and local sources. Of the total, $95 million was spent in foster-care payments, almost all of which came from State and local funds. Although 14 States used Federal money for this purpose, the amount used was very small. The remaining $26 million was spent for personnel, training, and administration. Federal funds accounted for about $1 out of every $5 used for these purposes.

The Years Ahead

In retrospect, the past 2 decades have truly been 20 years of progress for children. Maternal and child health, crippled children's, and child welfare services have steadily grown and developed, but the benchmarks that show how far the Nation has come in extending and improving these services also show all too clearly how far it has yet to go.

Coverage.—Some 700 counties are not served at all by a public health nurse—one of the most important services for promoting the health of mothers and children. Estimates of the number of children crippled with handicaps not orthopedic in nature are nearly 10 times the number with orthopedic handicaps, yet they represent less than half the children receiving physicians' services through State crippled children's programs. Some 1,255 rural counties still do not have available the services of a full-time public child welfare worker.

Training of personnel.—The shortage of personnel with professional training is one of the major obstacles in securing and maintaining qualified personnel in the States.

Research.—More research studies on the effectiveness of existing programs are urgently needed if full benefit is to be received from the experience of the past and new techniques developed in the light of this experience.

These are only a few of the challenges for the years that lie ahead for these programs.

Significant Events, 1935–55

1935

January 17: Report of Committee on Economic Security transmitted to Congress with recommendations for Federal old-age insurance, Federal-State public assistance and unemployment insurance programs, and extension of public health, maternal and child health, services for crippled children, and child welfare services, and vocational rehabilitation. Economic Security Bill introduced.

April 4: Social Security Bill introduced (replacing Economic Security Bill).

August 14: Social Security Act became law.

August 23: Members of Social Security Board named by President: John G. Winant (chairman), Arthur J. Altmeyer, and Vincent M. Miles.

August 29: Railroad Retirement Act of 1935 and Carriers Taxing Act of 1935 signed by President (to replace Railroad Retirement Act of 1934).

1936

January 1: Federal unemployment tax of 1 percent of payrolls first applicable to employers of 8 or more, with credit offset for contributions paid to State unemployment funds.

February: Public assistance payments to recipients first made with Federal participation under Social Security Act in old-age assistance (17 States), aid to dependent children (10 States), aid to the blind (9 States).

March 5: First Federal grant for administration of State unemployment insurance law (New Hampshire) certified by Social Security Board.

August 17: First State unemployment benefit paid in Wisconsin.

November: All States, the District of Columbia, Alaska, and Hawaii actively participating in program of maternal and child health services under Social Security Act.

1937

January 1: Workers began to acquire credits toward old-age insurance benefits. Employers and employees subject to tax of 1 percent of wages, up to $3,000 a year. Lump-sum payments first payable to eligible workers, their survivors, or their estates.

Federal unemployment tax payable by employers of 8 or more increased to 2 percent of payrolls.

May 24: Constitutionality of old-age and unemployment insurance provisions of Social Security Act upheld by U. S. Supreme Court. (301 U. S. 495, 548, 619).

June 24: Railroad Retirement Act of 1937 became law, amending portions of Railroad Retirement Act of 1935.

June 30: Unemployment insurance legislation became nationwide with approved laws in all States.

1938

January 1: Federal unemployment tax payable by employers of 8 or more increased to 3 percent of payrolls.

June 25: Railroad Unemployment Insurance Act became law.

September: All 51 jurisdictions making old-age assistance payments under Social Security Act.

1939

March 24: All States, the District of Columbia, Alaska, and Hawaii actively participating in program of crippled children's services under Social Security Act.

July 1: Federal Security Agency, set up by President's Reorganization Plan No. 1 of 1939, integrated in one unit the Social Security Board (to which was transferred the U. S. Employment Service), U. S. Public Health Service, Civilian Conservation Corps, National Youth Administration, and U. S. Office of Education.

August 10: Social Security Act amended to provide, under old-age and survivors insurance, benefits for dependents and survivors, advance payment of monthly benefits to 1940, revise the benefit formula, modify certain coverage provisions, and hold contribution rates for employers and employees at 1 percent each through 1942; under unemployment insurance, to modify definition of covered employment and make tax applicable only to first $3,000 in wages; to increase Federal share of public assistance payments; to raise annual authorization for grants for maternal and child health, crippled children's, and child welfare services and extend these programs to Puerto Rico. For unemployment insurance and public assistance, State personnel merit system made requisite for Social Security Board approval of State plan; also made condition for Federal grants for maternal and child health and crippled children's services.

1940

January: Monthly benefits first payable under old-age and survivors insurance.

January 18–20: White House Conference on Children in a Democracy held.

June: All States, the District of Columbia, Alaska, Hawaii, and Puerto Rico actively participating in program of child welfare services under Social Security Act.

1942

February 9: Social Security Board given certain responsibilities in program for aid to enemy aliens.

February 26: Social Security Board authorized to administer monthly benefits, assistance, and services to civilians affected by enemy action.

April 29: Rhode Island enacted first cash sickness insurance law, providing temporary disability benefits to those covered by State unemployment insurance law.

August 28: Emergency grants to States authorized for programs for day care for children of working mothers under plans approved by Children's Bureau and Office of Education, administered by Work Projects Administration.

October 21: Old-age and survivors insurance contribution rates frozen at 1 percent through 1943.

1943

March 18: Medical and hospital care for wives and infants of enlisted men in the four lowest grades of Armed Forces authorized to be administered by Children's Bureau, through Federal grants to State health departments.