

Twenty-five Years of Public Assistance

by **KATHRYN D. GOODWIN***

PUBLIC ASSISTANCE programs have played a vital role during the past 25 years in providing basic economic security to needy persons not eligible for social insurance or receiving benefits insufficient to meet their minimum needs.

Expectations of the planners of the Social Security Act thus have been realized. For, with far-sighted vision, they recognized that an effective social security program for this country must include both social insurance and public assistance—social insurance to provide a measure of social security against insurable risks, such as loss of income due to the unemployment, retirement, or death of the wage earner; and public assistance, a supplementary program, to deal with individual want inadequately met through social insurance or other programs.

The flexibility inherent in the public assistance programs has permitted their adaptation to changing needs as the economic and social scene shifted rapidly in the maelstrom of economic and social change during the past quarter century.

THE CHANGING ROLE OF PUBLIC ASSISTANCE

The Social Security Act, passed in 1935, included Federal grants in aid to the States to enable them to make more nearly adequate provision for the needy aged and blind and for children in their own homes who were needy because of the death, disability, or absence of a parent. In the words of the first Annual Report of the Social Security Board, "The public-assistance program outlined by the act . . . implies a new conception of the value to the community, as well as to the individual, of a broadly conceived public-welfare program, national in scope, but varying from State to State according to local needs and desires."

Between February 1936, when public assistance payments were first made with Federal financial participation, and January 1940, when the first

monthly benefits were paid under old-age and survivors insurance, public assistance programs carried major responsibility for providing basic economic security to these groups of needy persons. By January 1940, Federal funds were being used by 51 jurisdictions in providing old-age assistance, by 43 jurisdictions in aiding the needy blind, and by 42 in helping dependent children. The federally aided public assistance programs thus played an important part in preventing destitution for many needy persons in the transition from the emergency relief programs of the early 1930's to the activation of the long-range planning embodied in the social insurance provisions of the Social Security Act.

Today's Recipients

However, as the administrative machinery of the old-age and survivors insurance program gained momentum, and as amendments to the act in the ensuing years extended coverage and liberalized insurance benefits, the public assistance programs shifted into the secondary and supplementary role originally intended. Thus, by December 1959, while 9 out of 10 in the working force and their dependents had the protection of the old-age, survivors, and disability insurance program and nearly 14 million men, women, and children were receiving benefit payments, only 1 in 31 (fewer than 6 million) were receiving federally aided public assistance. In addition, more than a fourth of the aged receiving assistance in June 1959 needed such help to supplement insurance benefits in order to meet their minimum needs. For, as the 1957 survey of beneficiary resources showed, it was only when assistance was added to benefits and other resources that the total income per beneficiary-recipient approached the average for all aged beneficiaries.

In contrast to unemployment as the major factor contributing to dependency in the early 1930's when the Federal Government first assumed some responsibility for helping needy people, other handicapping conditions or per-

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sonal difficulties are contributing to the dependency of most people receiving public aid today.

More than a million old-age assistance recipients are over age 75; 3 out of 5 are women, and many are widows who have never been employed. Some are seriously ill; 1 in 30 is confined to bed, and 1 in 20 lives in an institution—usually a private nursing home. Half of those receiving aid to the blind are over age 63; most have been blind about 20 years and are totally blind or have very limited vision. All persons receiving aid to the disabled have a permanent and total disability; most have more than one impairment, with heart disease the most frequent; and about a fifth are so seriously disabled they cannot leave their homes. Many of the 2.3 million children receiving aid to dependent children suffer from emotional conflict, hardship, and instability in their family life, for most of them live in homes where one parent is either physically or mentally incapacitated, or deserted, separated, divorced, or not married. Many of the 1.1 million persons receiving general assistance are in need because of temporary illness or partial incapacity.

The expansion and liberalization of the old-age, survivors, and disability insurance program—which contributed to a 14-percent decline in the number of aged persons dependent on public assistance between 1950 and 1959 while the number of aged in the total population increased 25 percent—will undoubtedly result in a continuing decrease in the number of older persons dependent primarily on old-age assistance. It can be expected, however, that as the average age of persons receiving old-age benefits rises an increasing number will require supplementary aid to meet basic needs or special needs, such as medical care, if these are not met by any other program.

Legislative Changes

Provisions of the public assistance programs have been adapted to changing needs of dependent persons through amendments to the public assistance titles of the Social Security Act.

The scope and coverage of the programs were broadened by:

establishing a new federally aided category of aid to the permanently and totally disabled (1950);

extending federally aided programs to Puerto Rico and the Virgin Islands (1950) and to Guam (1958);

providing Federal financial participation in State public assistance expenditures for: (1) aged, blind or disabled recipients who are patients in public medical institutions (1950), (2) costs of medical care or other remedial care paid directly to doctors, hospitals, and other suppliers of such services (1950), (3) needy adults responsible for the care of children in the program of aid to dependent children (1950), (4) children aged 16 and 17, without regard to school attendance, and children living with first cousins, nieces and nephews (in addition to previously specified relatives) in the program of aid to dependent children (1956); and

placing increased emphasis on the provision of social services to help recipients achieve increased self-care, self-support and stronger family life by clarifying the objectives of public assistance as including both financial assistance and other services, and by recognizing that the cost of providing such service is a proper cost of administering public assistance (1956).

Federal financial aid to States was increased (1939, 1946, 1948, 1950, 1952, 1956, and 1958) through:

raising the maximum on the monthly amount of assistance for which Federal financial participation would be available (for example, from \$30 a month per individual in old-age assistance in 1935 to an average of \$65 a month in 1958);

increasing the proportion of Federal participation in that part of the assistance payment subject to Federal sharing (for example, from $\frac{1}{2}$ of the monthly money payment to old-age assistance recipients in 1935 to $\frac{4}{5}$ of the first \$30 a month average payment plus half the balance for money payments to recipients, and half of separate payments to vendors for medical and remedial care up to \$6 per recipient in 1956); and

revising the basis of Federal financial participation (1958) to increase Federal funds available to States, make possible greater flexibility in meeting individual needs of people, and simplify State fiscal procedures for claiming Federal funds, by these steps: (1) the fiscal ability of each State was considered in determining in part the Federal share of a State's expenditure for public assistance; (2) the Federal share was related to a single average expenditure per recipient for both money payments to recipients and vendor payments for medical care; and (3) the amount of State expenditures for public assistance (including medical care) in which the Federal Government will participate was established at an amount equal to \$65 a month times the number of aged, blind and disabled recipients in the State and \$30 times the number of recipients of aid to dependent children.

INCREASING ACCEPTANCE OF MEASURES PROMOTING WELL-BEING OF THE INDIVIDUAL

Consistent gains through legislative changes that broadened and strengthened federally aided

public assistance programs reflect their increasing acceptance as an integral part of the Nation's social institutions. The twenty-fifth anniversary of the programs thus provides the occasion for celebrating their maturing status and marks as well a significant milestone in changing attitudes toward relief of destitution.

In America, as a young country with rich natural resources, there was at first a general belief that almost everyone could achieve security for himself and his family through his own efforts, and that people who needed community help were shiftless or lazy. However, as the Nation became industrialized, the new economic order not only brought higher standards of living, better education, and less physical hardship, but also a new awareness that individuals were increasingly subject to the impersonal forces of a money economy.

The growing number of dependent aged persons and young children in the population also created new economic and social problems. The large, highly integrated, self-sufficient farm family was replaced by the smaller city family dependent solely on wages and increasingly subject to social strains that weakened family cohesion. Individuals and families became less able to provide for their own economic security in the face of hazards common to most people from time to time.

The mass unemployment of the early 1930's found the country ill-prepared to handle the destitution and suffering of millions that resulted when wages stopped. This helped to change the thinking of many people, for there was much evidence that destitution can result not only from personal inadequacies, but from forces over which the individual has little or no control. Increasing acceptance of the concept that it is morally wrong as well as economically unsound to let people go without needed help led to the planning that culminated in the passage of the Social Security Act.

The provisions of the public assistance titles of the act, reflecting respect for the dignity of the individual and recognition of his rights as well as of his responsibilities, helped the States to raise public assistance far beyond earlier relief practices. For example, the definition of assistance as a money payment, in contrast to the earlier usual relief in kind, leaves with the needy

person responsibility, like that of others in the community, for deciding how best to use his income. Provision for a hearing before the State agency protects individual rights when a needy person has been denied aid or is dissatisfied with the amount of his assistance payment, or when his application has not been acted upon with reasonable promptness. His privacy is safeguarded by preventing disclosure by the agency of personal information for purposes other than the administration of the program.¹ Higher standards for the care and protection of needy people in institutions have resulted from the requirement enacted in 1950 that each State designate an authority responsible for establishing and maintaining standards for institutions in which recipients of federally aided assistance reside.

Strengthening Welfare Services

Clarification, through a 1956 amendment, of Federal financial participation in the costs of providing, in addition to financial aid, other staff services stimulated renewed and strengthened activities by the States in helping needy persons to find and use their own strengths and available resources to develop their potential for more satisfying and independent living. Although the extent and quality of welfare services being provided vary greatly across the country, heartening advances are being made in the number of people helped to greater self-sufficiency, some savings are resulting from decreased assistance costs, and the benefits of cooperative effort between public and voluntary agencies and other groups in the community are being demonstrated.

Services most generally provided have been in relation to health needs of children and adults, and in improvement of home conditions for children. For example, public assistance workers have increasingly provided or arranged for services that enable the needy aged or disabled per-

¹ Although modified in 1951 by an amendment that permits public inspection of the disbursement records, both the law and practice still affirm the principle that dependency should not subject assistance recipients to indignities or embarrassment. One State reported that the 386 requests made to inspect the assistance rolls between 1953 and 1958 resulted in the closing of only one case and the withdrawal of only one application.

son to remain in his own home and with his family and friends as long as possible. Some skilled workers have helped with more intangible but equally serious emotional problems. Projects in several States have arranged for specialized services and home helps that enable some aged persons in nursing homes and mental hospitals no longer in need of institutional care to return to normal living patterns in the community. Other projects, using a team including doctors, rehabilitation and employment counselors, and social workers to consider latent capacities and resources of handicapped individuals, have helped some disabled persons to become self-supporting or to embark on plans for at least partial rehabilitation.

Improving Medical Care Provisions

Measures designed to improve medical care provisions for the needy were also taken through amendments to the act in 1950, 1956, and 1958. Under the original act as passed in 1935, Federal financial participation in State expenditures for medical care was available only to the extent such costs were included in the monthly assistance payment to the recipient within the limits of the Federal maximum on the monthly assistance payment. A 1950 amendment broadened the definition of "assistance" to include vendor payments,² but the amount still had to come within the specified individual matchable assistance payment. Since the amount of medical care that could be thus provided was limited, some public assistance agencies used a pooled fund—a prepayment arrangement—into which a fixed monthly payment was made for each recipient, and from which was paid the costs of medical care for individual recipients, since the averaging of costs helped to some extent in meeting the higher medical care costs in individual instances.

To meet the increasing need for medical care and its higher cost, an amendment in 1956 permitted, in addition to the matching on individual money payments, separate Federal sharing in a State's total expenditures for vendor payments up to one-half of the sum of \$6 times the number

of adult recipients and \$3 times the number of child recipients per month. Within several months, this additional Federal aid enabled 11 States with no previous statewide provision for medical care to begin to pay the cost of some medical services for the first time through vendor payments, and 11 others to expand their existing medical care provisions.

By January 1958, 36 States were using the vendor payment method for meeting costs of some items of medical care. However, relatively comprehensive medical care was provided under public assistance in only 10 States and in most of these, payments were made primarily for treatment services and included but little for preventive services. Some of the other States, for example, provided only for hospitalization in life endangering conditions.

Further effort, therefore, was made to increase the availability of medical care through an amendment in 1958 that changed the basis for Federal sharing in State expenditures to include the provision of medical care costs with other kinds of items in assistance payments within the new general averaging formula. The use of an average in determining the amount of the Federal share, which made it possible for States to receive matching for larger medical care expenses in individual cases, resulted in the development of provisions for making vendor payments for medical care costs by additional States.

By June 1959, 42 States had some provision in their public assistance programs for the payment of costs of medical care through the vendor payment, and all but two of the remaining jurisdictions provided for some items of medical care in the money payment to the recipient, although still within the limitations of the State's maximum on assistance payments. Nursing-home care, the item most frequently covered, was provided by 49 out of 54 jurisdictions (March 1960)³; 13 used the vendor payment method only, eight used both the vendor payment and money payment, and 28 used the money payment only. Hospitalization was also provided under public assistance programs in 34 out of 54 jurisdictions through vendor payments only; 7 of the other jurisdictions had other State systems of

² "Vendor payments" are defined as payments for medical care or other remedial care made directly to the suppliers of such services.

³ The 54 jurisdictions include the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

hospital care available to needy persons or other known sources of care.

Strengthening Family Stability

Thus, the financial assistance, medical care, and other social services available under the provisions of federally aided public assistance programs in most of the 3,100 counties in the United States have contributed much to the strengthening of family ties that might otherwise have been scarred by anxiety and poverty or broken by separation of children from their home and parents.

The program of aid to dependent children has enabled the needy parent and child to remain together in their home, and has given the children an opportunity to grow up within their own family setting and to continue their schooling.⁴ The mother or other relative caring for the children has been enabled to continue the rearing of the children and in other ways to carry the usual parental role in the family and community.

The other federally aided programs, through serving the needs of individual adults, have in many instances also contributed to family stability. The needy aged, blind, or disabled individual often has been enabled to remain at home and to continue to carry his usual role in the family; his presence undoubtedly has contributed much to the affection provided children within their own family setting and to the cohesion of the family group. Similarly, as contributing members of their families, most old-age assistance recipients have not had to seek the protection of old-age homes before custodial service became essential; the average age of applicants to homes for the aged is about 75.

GAPS, INEQUITIES, AND OTHER PROBLEMS

The twenty-fifth anniversary provides not only a benchmark by which to measure progress, but also a good place to stop and take stock of gaps, inequities, controversial areas, and other prob-

⁴ Reports from States indicate that 97.8 percent of the children aged 6-17 who were recipients of aid to dependent children were regularly attending school between October and December 1958.

lems limiting the most effective use of public assistance in helping people to meet their essential needs when they are unable to do so themselves and no other resources are available to them.

Many Not Eligible for Assistance

Excluded from the federally aided public assistance programs are (1) the needy unemployed and the underemployed and their dependents, (2) the less seriously disabled, (3) the "not-old-enough" aged, (4) mothers of dependent children when the youngest child reaches age 18, (5) needy children in foster homes and in public or private institutions, (6) needy persons in non-medical public institutions, (7) patients in hospitals for tuberculosis or mental diseases, (8) patients in medical institutions as a result of a diagnosis of tuberculosis or psychosis, and (9) needy persons who meet some, but not all, of the eligibility requirements established by the States, such as residence and "suitability of the home."

Some of these "excluded" needy persons—mostly temporarily or permanently unemployable persons—are aided by State and/or locally financed general assistance or institutional care. However, in 17 States, employable persons and their families cannot receive aid even when limited education, lack of job skills, or discrimination prevents their earning enough to live decently and healthfully; or when they are unemployed, even though they are ineligible for unemployment insurance or receive benefits too small to maintain them. In a few States, only some people in the direst circumstances can receive some assistance at some time. Nonresidents in most States are aided only in emergencies, and effort is made to return them to their State of residence as quickly as possible; only 14 jurisdictions have no durational residence requirement.

Thus, although general assistance aided 1.1 million in December 1959, there are still many persons throughout the country with serious financial needs for which no resources are yet available.

Assistance Payments Not Meeting 'Need'

Public assistance programs have come a long way during the past 25 years in providing more

help and in extending such help to additional groups of needy people. Federal, State and local governments have increased their expenditures substantially. But with rising costs and the shrinking value of the dollar, fewer than half the States are fully meeting "need,"⁵ judged by standards they themselves have set. The other States either impose maximums on the monthly amount of assistance any individual or family may receive or meet only a specified proportion of need.

In some States the standards themselves are inadequate. They either have not been revised in content or priced recently enough to maintain their currency in providing generally accepted and validated essentials of living. Other inadequacies result from State policies for evaluating the resources of recipients—for example, counting as income expected contributions from relatives that fail to materialize.

Under general assistance in many States, limited funds and stringent standards applied in determining the degree of destitution that must exist before State and/or locally financed assistance is granted keep the number of people and the amount they receive at a level below payments in the federally aided programs. Excluding vendor payments for medical care, the average amount per recipient of general assistance in December 1959 was \$25.09 compared with \$56.70 per recipient of federally aided old-age assistance.

Inadequate Provision To Meet Medical Care Costs

Although considerable progress has been made by many States in providing for more medical care services for more needy persons, wide variation exists both among the States and among the categories of needy persons in the types and quantities of medical care provided through public assistance, as well as in the medical care available without charge from other State and local resources. Furthermore, medical care provisions in most public assistance programs include only a few medical services.

⁵ "Need" is defined here as the gap in income between the total cost of living essentials set by the State and the individual's resources to meet that cost.

For example, a fourth of the 34 jurisdictions that provide for hospitalization through public assistance vendor payments restrict payment for such care to acute illness or injury. (Seven of the 20 jurisdictions without provision for hospitalization under public assistance have other State systems of hospital care or other known sources available to needy persons.) The amount provided for medical care within the money payment is also limited by the State's maximum on assistance payments.

Thus, average monthly expenditures per recipient for vendor payments for medical care in December 1959 were \$11.16 for the disabled, \$9.73 for the aged, \$6.05 for the blind, and \$1.77 for recipients of aid to dependent children. Comparable averages for recipients of general assistance are not available, though it is known that, in some areas, the expenditure amounts to only a few cents per person. In terms of today's high cost of medical care, it is evident that both in quantity and quality the unmet need is still considerable, since public assistance recipients include persons most in need of medical care and yet least able to pay for it. In the few States that provide fairly comprehensive medical care, average monthly expenditures per recipient of medical care are four to five times as high as the national average.

The rising cost of medical care services is of great concern to public assistance agencies in their efforts to keep a balance in expenditure of available funds between maintenance and medical care needs, as well as to other community agencies. For example, one State reported that one of its county health departments in a routine check of school children was not only concerned at finding a large number of children showing evidences of malnutrition but was also distressed to learn that most of these children were recipients of aid to dependent children.

To meet both medical care (including preventive and rehabilitative services) and maintenance needs more nearly adequately would require increased expenditure in many States. But there is little doubt that low income, malnutrition, untreated illness and debilitating chronic conditions create a vicious circle, with ultimately higher cost to the public and loss of independence for the individual. Until all people have income adequate for health and well-being, great social and hu-

man waste will occur—waste that affects not just those without enough income but the welfare of the Nation.

Inequity Between Provisions for the Needy Aged and Those for Dependent Children

The higher national average monthly payment, including vendor payments for medical care, of \$65.86 for an aged recipient compared with the \$29.02 payment per recipient of aid to dependent children (December 1959) may be related to some extent to the greater need of the aged for medical care and the availability of more care for them in many States. But undoubtedly it also reflects greater public acceptance of old age as a cause of dependency than of divorce, separation, desertion, or unmarried parenthood—the causes most frequently associated with dependency of the children receiving aid to dependent children—today, about 60 percent—of the caseload.

Even though there is evidence of social problems at all income levels, the concentration within aid to dependent children of families whose need is associated with socially disapproved behavior has increasingly made this program a target of criticism as more information has become available about the causes of dependency. Earlier concern related to families where the father deserted; more recently, attention has been focused on families where the father has not married the mother.

One in 25 of our Nation's children is illegitimate. The socially unacceptable behavior of the parents of the one in 200 who is illegitimate and in need has been widely publicized and used by some as the basis of proposed legislation and administrative regulations directed against aid to dependent children in general. Most of these legislative proposals have never become operative. But others, which indirectly control the assistance payment through eligibility conditions and low payments, have resulted in depriving already disadvantaged children of needed support and care. The focus of concern—the 1 in 8 children receiving aid to dependent children whose need is directly related to unmarried parenthood—while of grave significance, has tended to obscure the value of the program in sustaining hundreds of thousands of needy children and helping

thousands of families to remain together—a sound investment in the moral and physical well-being of our growing generation.

The report, *Illegitimacy and Its Impact on the ADC Program*, prepared by the Bureau of Public Assistance at the request of a congressional committee and issued in April 1960, identifies the problem of illegitimacy as one that long preceded the establishment of public assistance programs, with causes deeper than the availability of financial aid. The report also cautions that it is no solution to the problem of the child or the community to deny assistance while leaving the child in endangering conditions and suggests that any lasting solution must deal with the causative factors and must move forward on many fronts.

In the meantime, as the report points out, aid to dependent children has an obligation to carry out the purpose expressed in law of providing financial aid and other services to strengthen family life. Financial aid for children who would otherwise go hungry is not an insignificant matter. Health and growth may be dependent upon it, and the future lives of children may be warped by its lack. Children also need a proper environment in which to grow up. When the child's own home can be preserved, help should be available to the mother in improving her ability to provide a proper home, in establishing the role of the father where possible, and in aiding the family to assume a normal role in the community.

Inadequate Provision of Other Social Services by Qualified Staff

The 1956 "services amendment" stimulated increased planning for the provision of other welfare services to help needy persons increase their capacity for self-care or self-support and to maintain and strengthen family life. However, because of staff limitations and heavy workloads, the States' services plans, in general, realistically defined their responsibility by limiting the problems for which services would be provided, limiting services to those required in the determination of eligibility for money payments, or limiting services to those that could be provided only during regular contacts for eligibility determination.

The States are increasingly aware of the importance of making staff time available for supportive services in addition to financial aid needed by many of the aged, the disabled and one-parent families. But high caseloads and lack of staff skills also limit the availability and quality of services that can be provided by most agencies, since this kind of help usually needs the knowledge and skill that comes from professional social work training. The fact that only about 2 percent of public assistance caseworkers have full social work training and only 15 percent have partial training reflects not only the nationwide shortage of social workers but also the lack of their attraction to public assistance jobs because of relatively low salaries (compared with those in other governmental and voluntary agencies), heavy workloads, and a complex of professional and clerical content in the job.

Although the "training amendment" in 1956 authorized additional Federal funds to help States to increase the number of persons qualified for work in the public assistance programs, no funds have yet been appropriated. In the meantime, alternative methods of increasing the competence of staff and making more effective use of the limited number of skilled staff are being explored. Some States have stepped up in-service training and, increasingly, agencies are granting educational leave under the 50-50 provision for Federal participation in administrative costs; 39 State agencies granted such leave to 402 staff members in 1959.

A LOOK TO THE FUTURE

Amendments to the Social Security Act in 1958 included a provision for the establishment of an advisory council to review the status of the public assistance programs in relation to old-age, survivors, and disability insurance, the fiscal capacities of the States and the Federal Government, and any other factors bearing on the amount and proportion of the Federal and State shares in the public assistance program. Their report, *Public Assistance—A Report of the Advisory Council on Public Assistance*, submitted to Congress on December 31, 1959, including recommendations that reflect the consensus of a 13-member group with wide diversity of backgrounds and interests, points up significant areas

for further consideration. For, while most of the recommendations deal with Federal-State methods of sharing the financial burden of assisting persons in need, they do so with a focus on finding ways of meeting unmet needs, improving assistance standards, and strengthening family life. They recommend, for example, that—

Coverage be extended to all needy persons regardless of the cause of their need by:

- a. using Federal grants-in-aid to encourage States to include additional needy persons, such as the unemployed, the under-employed, and the less seriously disabled (and to reevaluate exclusions now in the law specifically directed to needy persons in certain institutions and foster homes)—giving the States freedom of choice in determining whether to administer public assistance as a single program or as separate categorical programs, and suggesting several options: a single category for all financially needy persons, adding a new category of general assistance to existing categories, retaining one or more existing categories and consolidating remaining needy groups in a single category, or expanding existing federally aided categories to include additional needy persons;
- b. expanding the aid to dependent children program to include any financially needy children living with any relative in their own home;
- c. limiting the use of Federal grants-in-aid to State programs imposing no residence requirements for eligibility.

Standards of assistance be raised by:

- a. creating greater public understanding as to what constitutes a level of living sufficient to maintain health and well-being, with Federal leadership in (1) the development of up-to-date budget guides for typical families, (2) requiring States to report on the relationship of their own budgets and actual payments in relation to these budgets, and (3) publishing the data received from the individual State reports;
- b. extending the scope and improving the quality of medical care for which assistance payments are made without reducing money payments to recipients (through cooperative efforts of Federal and State governments and voluntary agencies, with greater Federal leadership and the help of a broadly constituted Medical Care Advisory Committee);
- c. raising Federal maximums high enough so as not to hamper State efforts to provide assistance at levels adequate for health and well-being and to meet rising costs of basic living requirements and medical care;
- d. raising Federal maximums for ADC to an equitable relationship with the other programs, with any differences reasonably related to differences among the groups in the cost and content of their living requirements; and
- e. encouraging the States to apply the same assistance standards to all categories of needy persons and to ensure that similar treatment is accorded to persons in similar circumstances.

Individual and family life be strengthened by:

- a. appropriating funds authorized by Congress in 1956 for research and demonstration projects relating to strengthening family life and the reduction and prevention of dependency;

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.

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