shall increase the professional and economic opportunities of our physicians, dentists, and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this especially at this time because of the return to civilian life of many doctors, dentists, and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

HARRY S. TRUMAN.

THE WHITE HOUSE,
November 19, 1945.

How Can We Assure Adequate Health Service for All the People?

By A. J. Altmeyer*

IF WE ARE to bring health services to all the people, the medical profession and the Government must work together. Obviously, the Government cannot achieve this objective without the cooperation of the medical profession, because medical service must be furnished by the medical profession. I believe it equally true that the medical profession cannot achieve the objective without the help of the Government.

At the outset, may I state plainly my opinion that there is no disagreement in our desire and determination that everybody, regardless of financial circumstances, shall be able to have adequate health services—meaning essential services of good quality. None of us wants to see anybody suffer or die for lack of medical care.

I believe also that the standards of good medical practice and of good hospital care in this country are probably second to none in the world today. The medical profession and hospital administrators have a right to be proud of the great progress these standards represent.

It is also true that, with few exceptions, the death rate in this country has declined year after year, particularly since the turn of the century. In 1900 there were 17 or 18 deaths per thousand of population, as compared with 11 per thousand in 1940. This is indeed notable progress.

Since all this is true, it may be asked, "Why is it necessary to embark on a national health program?" And, especially, "Why is it necessary for the Government to assume major responsibility?"

The answer is twofold. In the first place, while we have made notable progress in reducing the death rate, we are not the healthiest nation in the world. In the second place, while we have achieved high standards in medical and hospital care, this high-quality care is not within the actual reach of large numbers of our people. Putting it bluntly, there are many Americans this very minute who are suffering and dying needlessly for lack of medical care.

Not the Healthiest Country in the World

The statement has been made many times that we are the healthiest nation on earth, but statistics for the years just preceding the war show conclusively that we are not. Probably the best single measure of our relative health status is the infant mortality rate. In terms of this index, we stood seventh. Moreover, the comparisons in general were increasingly unfavorable to us as we proceeded from the death rates for infants to those of older groups of our population.

Even if we restrict the comparison to the white population, excluding data for Negroes, who have higher death rates, our mortality rate was by no means the lowest. For example, before the war the white male population of the United States ranked fifth among the nations of the world in the average expected years of life at the time of birth.

In spite of our wealth and our high per capita income, our death rates are not the best. Before the war, other countries, with much more modest economic resources, had gone further than we had in preserving human life.

In addition, we should not draw too much satisfaction from the fact that our death rate has declined markedly since the turn of the century. We should not forget that about 70 percent of the reduction was made by 1920 and almost all of it by 1930. We must also remember that the major part of the reduction in death rates has been due largely or almost wholly to the reduction in deaths from infectious diseases that are susceptible of mass control. If we are to have anything like a similar improvement in death rates in the future, we must not only expand our efforts in the mass control of infectious diseases but also assure more nearly universal access to individual medical care of noninfectious diseases.

What should concern us more than comparisons with other nations or with former years is the fact that we have done much better in protecting health in some places than in others, for some types of diseases than for others, and for some groups of the population than for others. The real measure of our past accomplishments and of our future opportunities is what we can do with our available knowledge. In many parts of the country and among many groups of our people, death rates are far higher than they need be. For example, many States go through a year without a single reported death from diphtheria or typhoid and paratyphoid fevers; yet other States are reporting three to four deaths from these causes per hundred thousand persons.

I cite these diseases not so much because of their present importance as causes of death but because they are diseases that can be almost completely prevented with proper public health and medical measures, and yet they continue to snuff out many lives annually.

Tuberculosis is still one of the dread killers. Yet we find that in a number of States death rates from tuberculosis are only one-fifth or one-sixth as high as in States with the highest rates. If the national death rate from tuberculosis had been as low as the lowest actually achieved in any States in 1943, some 42,000 lives would have been saved in that year.

Infant mortality illustrates similar wide differences among the States. In 1943, the State with the lowest in-

*Chairman, Social Security Board. Speech at First Annual Conference of Presidents and Other Officers of State Medical Societies, Chicago, December 2, 1945.

fant mortality reported 29 deaths per thousand live births; the State with the highest mortality had more than 3 times that rate. In some half-dozen States with the highest infant death rates, at least half the babies who died could have been saved had they been fortunate enough to have been born in areas where conditions were more favorable for their survival.

In this connection, the relationship between infant mortality and medical attendance at birth deserves mention. In the 10 States with lowest infant mortality in 1942, 88 percent of the births in that year took place in hospitals and less than 1 percent lacked medical attendance. In contrast, in the 10 States with the highest infant mortality, only 47 percent of the births were in hospitals, and 12 percent had no medical attendance.

Financial Barrier to Adequate Medical Care

The availability or absence of medical care is not the only reason for these and other differences in the security of life in the United States. Differences in economic circumstances, and consequently in housing and living conditions, no doubt contribute to the differences in death rates. No economic factors, however, are as significant as the availability of public and individual provision of health and medical services.

It is still commonly said that the poor and the rich get the best care. This oft-repeated generalization has caused much confusion. The fact is that poor people have more illness and have higher death rates than the well-to-do, but they receive far less medical care per family and per case of sickness. Poverty, illness, and inadequate medical care go together. The National Health Survey, conducted by the United States Public Health Service in the winter of 1935–36, showed that there were 2½ times as many days of disability among persons on relief as among those having a family income of $3,000 or more. The number of days lost by persons not on relief but with a family income of less than $1,000 was twice that experienced by those with a family income of $3,000 or more.

This Survey also showed that while there was much more serious disability among those with the least income, a substantially larger proportion among them than among those in the higher income brackets failed to receive any medical attention whatsoever. Those who did receive medical assistance had had fewer visits from physicians than disabled persons in the higher income brackets. In brief, it was shown that the amount of medical care received by persons in the low income brackets has been about one-third as adequate as the care received by those in the upper income brackets.

The reason for this difference should be obvious. Medical care costs money and the poor have less money to pay for it. Various public opinion polls show that from 30 to more than 40 percent of the American people have put off going to a doctor because of the cost. Individual doctors are not to be blamed for this. Financial barriers—not doctors—are the cause of the inadequate medical care which our people receive.

Government Responsibility for Meeting Health Needs

If we agree that nobody should suffer or die for lack of access to medical care, do we not have an obligation to break down the financial barrier between sick people and their doctors and hospitals? Is a democratic government meeting its full responsibility if the primary essential of human existence—the health of the people—is not safeguarded and improved to the utmost extent that medical science and our resources make possible?

That this is an accepted responsibility of government is recognized by the fact that our Government has already gone a considerable distance in protecting and promoting the health of the people. In addition to public sanitation and public health services, we have provided public medical services for the indigent, though with widely varying degrees of adequacy in different localities. Nor has governmental assistance for medical care been limited to indigents. In 1944, 85 percent of all the beds in tuberculosis hospitals were in government-operated institutions. Hospitalization for persons afflicted with nervous and mental disease has become almost exclusively a government function, and this hospitalization has by no means been limited to the indigent.

Even in the field of general hospital care the role of government has become increasingly important. In addition to the hospitals for veterans and other wards of the Federal Government, about 28 percent of all the beds in general and special hospitals are in government-owned institutions.

Through workmen's compensation laws, the States and the Federal Government have assured medical services for work-connected accidents and diseases.

Of course the Federal Government has always been responsible for the medical services of the armed forces. In addition, it has provided hospital and medical care for merchant seamen for a century and a half. For more than a quarter of a century special provision has been made to assure hospital and medical care for veterans. This activity is destined to grow by leaps and bounds. In the next 30 to 40 years, it is estimated, the Government will be providing hospital and medical care for 15 to 20 million veterans.

Under the Social Security Act, the Federal Government has made grants-in-aid to States for maternal and child health services, services to crippled children, and State and local public health services. It also has been providing funds for the control of venereal diseases.

Since 1942 the Federal Government has been paying for the maternity and infancy care of the wives and infants of servicemen. During the last fiscal year the expenditures under this program alone amounted to $45 million.

Last year the new Public Health Service Act became law, increasing the financial support for public health and for research and authorizing a new, large-scale attack on tuberculosis. All in all, in 1944 governmental expenditures—Federal, State, and local—for public health and medical services, exclusive of medical care for the armed forces, totaled nearly a billion dollars, or one-fifth of all the expenditures for health and medical care in the United States.

Thus it is apparent that the question before us is not whether the Government should assume responsibility for protecting and promoting the health of the people, but rather how much further the Government should go in meeting that responsibility.

President Truman's Health Message

The President of the United States has placed his views before the Congress in his Message of November 19,

in which he outlined a national health program, consisting of five proposals.[1]

Time will not permit me to discuss fully all these proposals. Therefore, I shall discuss only that for a Nationwide system of health insurance, since it is the most controversial and probably of greatest concern to practicing physicians.

The question is whether it is still necessary for the Government to take some action to spread the cost of medical care for self-supporting individual families if it does these other things proposed, concerning which there is more or less general agreement. That is to say, would it be enough if the Federal Government expands its public health and maternal and child health programs, makes certain that hospitals, health centers, clinics, and diagnostic facilities are available in every part of the country, and finances the cost of providing care of the indigent? If all that is done, why cannot the normally self-supporting families be expected to pay for their own medical care either directly or through voluntary insurance plans of one kind or another? These are questions that deserve careful consideration.

Perhaps we can all agree that building hospitals and other health facilities is not enough unless provision is made so that sick people can avail themselves of these facilities. Unfortunately, in the very nature of the unpredictable incidence of sickness, it is impossible to draw a line between those who will and those who will not be able to pay for the health services they need.

"Medically indigent" is a statistical term to describe classes of persons rather than individuals. Whether a given individual falls within the classification of medically indigent depends not only on his income but also on the amount of sickness that he happens to have. Dr. Leland, Director of the Bureau of Medical Economics of the American Medical Association, presented data in 1939 in which he showed that people with incomes up to $3,000 a year may be medically indigent in certain circumstances—depending upon the type of illness they suffer.

In 1935–36, more than 92 percent of the people in this country were in families that had an income of less than $3,000. Even with the increase in per capita income since that time, the majority still have an income of less than $3,000, which of course purchases far less today than it did 10 years ago. Therefore, the fact remains that only a fraction of our people can pay for all needed medical services for serious illnesses.

If sickness were predictable and if it affected families equally, the problem of paying for needed medical services would be less serious. But, as we all know, sickness costs often come suddenly, unexpectedly, and in large amounts. One illness may involve a cost of only a few dollars and another may require more than the family income for weeks, months, or even years. No one knows when an illness may strike or how much it will cost.

Spreading the Cost of Medical Care

The only way most of the American people can meet this problem is by spreading the cost of medical care over sufficiently long periods of time and among large enough groups of persons so that the cost will not be unbearable in the individual case. If this were done and the average amount were adjusted according to income, the cost of adequate care would not be unbearable even for persons with relatively small incomes.

Some people have suggested that it should be sufficient to spread only the cost of so-called catastrophic illnesses, that is, illnesses costing more than a certain amount. One disadvantage of that approach is that people of low or medium incomes would still have to bear a considerable cost. Another disadvantage is that if they had to pay, for example, the first $50 of the cost, they would still be deterred from consulting their physicians early in the course of a disease or for an apparently minor illness which later proved to be serious. Thus, the great advantages of early diagnosis and early treatment would be lost.

If the problem is to spread the cost of medical care, the question remains why can't we rely on the individual to obtain his own insurance? Hard facts spell the answer. The poor cannot afford to pay the full insurance premium. Most of those who are normally self-supporting have immediate wants which press on them to the exclusion of protection against future possible costs that may not actually occur. In other words, our day-to-day wants and necessities induce us to take a chance.

Inadequacy of Existing Voluntary Arrangements

It is true that many people have insurance against the cost of hospital or medical care. The Blue Cross movement, in particular, has shown remarkable progress in the last 10 years. However, the present membership covers less than 13 percent of our entire population and is made up chiefly of people in the middle income brackets, who live in or adjacent to the larger cities. Prepayment plans for medical care preceded the Blue Cross hospital plans, but they have not shown such rapid or extensive growth. Some medical society plans that started out to provide comprehensive services have found their growth discouragingly slow and have restricted their main coverage to surgical expenses in hospitalized cases only. At present, membership in voluntary medical prepayment plans—which seldom provide complete or comprehensive services—includes about 5 to 6 million persons.

Commercial group insurance covers about 8 million persons for hospital and surgical indemnity insurance, of whom about 6 million are covered for surgical indemnity. The number of individual insurance contracts for indemnity of hospitalization and other medical care costs is not known. While it may be large, the scope of the protection is usually narrow, since many of these policies cover only costs incurred for particular types of accidental injuries, rather than sickness costs of all kinds, and many have other important limitations.

It is possible that, altogether, about 40 million persons have *some* voluntary protection against the costs of hospitalization or medical services. While this protection is significant, the available figures indicate that voluntary insurance alone does not assure adequate protection for most Americans against the cost of medical care. Moreover, when we consider the economic status of those who now have such protection and of those who do not have it—but do experience more frequent and serious illnesses—it becomes all the more evident that voluntary insurance is not a complete or adequate answer to this national problem of spreading the costs of medical care.

[1] See pp. 7–9, this issue.

"State Medicine" vs. *Health Insurance*

There are two possible ways in which the Government can undertake to spread the costs of medical care. One is through providing medical care free of charge to the recipient, financing it through general taxation. The other way is through a system of health insurance, financed largely through contributions by potential beneficiaries and their employers. Under the first approach, medical care would be provided just as education is now provided. The practitioners would probably be for the most part salaried officials employed by the agency of Government providing the medical services. Such a system is usually termed "state medicine" and sometimes "socialized medicine." However, these terms are so indefinite and confused that they are sometimes used to cover not only public sanitation, public health services, and medical services provided by Government for specific groups in the population, but also health insurance.

It is essential for clear thinking that the distinction between state medicine and health insurance be kept in mind. State medicine implies medical services provided by physicians employed by the Government; health insurance, on the other hand, implies a system whereby medical service is provided by private, competitive practitioners who are reimbursed from a special insurance fund for the services they render. In other words, state medicine is not only a system for spreading the cost of medical care but is also a system of medical practice; in contrast, health insurance is a system for spreading the cost of medical care and does not replace the competitive private practice of medicine. Only the Union of Soviet Socialist Republics has a national system of state medicine; more than 30 countries have a national system of compulsory health insurance.

Every State but one already is operating a system of compulsory health insurance applicable to accidents and diseases arising out of occupation—that is, workmen's compensation. I am sure that no one would think of abandoning workmen's compensation insurance. It seems generally agreed that, in spite of recognized deficiencies, workmen's compensation has resulted in providing more adequate medical care for the victims of work accidents and diseases and more adequate compensation for the physicians and hospitals called upon to treat them. In the broader sense, health insurance is merely more inclusive than workmen's compensation; it covers *non*occupational accidents and diseases.

Elements of a Health Insurance System

Many people sincerely believe that there is no essential difference between state medicine and health insurance. Perhaps outlining the elements of a system of health insurance will help to clarify the distinction. But first let me point out that health insurance is, of course, a form of social insurance. In addition to a form of health insurance—that is, workmen's compensation—this country now has unemployment compensation and old-age and survivors insurance. All these are forms of social insurance and are financed by premiums collected as a percentage of pay roll.

It would be possible to have a system of health insurance on a strictly State-by-State basis, like workmen's compensation, without any assistance from the Federal Government. Or it would be possible for Congress to enact legislation which would create a strong inducement for the States to enact such laws, as was done in the case of unemployment compensation. Or it would be possible for Congress to enact a wholly Federal health insurance law.

Decentralization of administration.—If Congress enacted a wholly Federal health insurance law, it would still be possible to allow for State administration. Contributions to finance the health services could be collected along with the contributions made under the Federal old-age and survivors insurance system without any additional inconvenience to employees or employers and without additional cost to the Government. The added cost of administering health insurance as part of a unified social insurance system probably would not exceed 5 percent of the total cost of the benefits provided.

Free choice for patient and doctor.—The administration of the benefits should be decentralized so that all necessary arrangements with doctors and hospitals and public health authorities could be subject to adjustment on a local basis. The local hospitals and doctors should be permitted to choose the method of remuneration they desire. The method of remunerating hospitals could be on a fixed per diem basis regardless of the cost of the service to the hospital or to the patient, or it could be on the basis of the actual cost of the service to the hospital—within fixed minimum and maximum limits—or it could be a combination of the two methods. The payment of doctors could be on the basis of fee for services rendered or a per capita fee per annum, or straight salary—part time or full time—or it could be some combination of these arrangements.

Besides free choice of method of remuneration, the system should provide, of course, free choice of physicians and free choice of patients. The professional organizations themselves should be relied upon to assist in the maintenance and promotion of desirable professional standards.

Both individual and group practice should be permitted. It would be hazardous for a layman to undertake to discuss with physicians the pros and cons of individual practice versus group practice. May I merely suggest that the development of adequate health facilities throughout this country, including hospitals, clinics, health centers, and diagnostic facilities available to all of the physicians in a community, ought to help us achieve the maximum advantages of both individual and group medicine?

Utilization of voluntary organizations.—Voluntary organizations that provide health services would have an important role under a system of health insurance. So would voluntary cooperative organizations that are concerned with paying doctors, hospitals, or others for health services but do not provide these services directly. Specifically, medical society plans that provide services directly or pay for services rendered could play an important part in simplifying administration, promoting desirable professional relations, and furnishing—or arranging to furnish—adequate medical care promptly and efficiently.

President Truman has specifically stated in his message that such voluntary plans should be preserved, used, and encouraged. Here is what the President said:

> Voluntary organizations which provide health services that meet reason-

able standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

Last year a group of 29 leading health experts, including 13 doctors of medicine, made a careful study of principles and policies for a national health program and concluded that it was desirable and practicable to utilize voluntary agencies in the administration of such a program.

Many State medical societies have worked hard to set up systems of prepayment of medical care. They have encountered great difficulties, but several of these plans have met with considerable success. Whether or not they have met with success, however, these plans represent an earnest attempt on the part of organized medical groups to spread the cost of medical care while maintaining the professional relations desired by those groups.

They have experienced one great difficulty that a general system of social insurance would overcome—the hazard of adverse selection. Any prepayment plan covering persons who can enter it and leave it at will is subject to this handicap. Under a general social insurance system, however, the problem of adverse selection is solved automatically, since the good as well as the bad risks are included.

Under a system of health insurance, the Government could make arrangements to deal with the voluntary groups that furnish health services directly or pay for services rendered. The simplest arrangement would be for the Government to reimburse the organization either on an individual patient or service basis, or on an estimated total cost basis, having regard for the number of insured persons that it serves. Such a relationship would involve a minimum of control by the Government and a maximum degree of independence on the part of the group and the members composing the group.

Such arrangements would not only provide for utilizing existing service organizations but would also encourage the creation of new ones. Such voluntary plans could be administered by groups of doctors, individual doctors, or many other kinds of individual or group sponsors.

Any such plans would be as free as they are today to select their own staffs and their own method of paying doctors and others on their staffs.

Moreover, the method of paying a group for services rendered by their physician-members can be readily adapted to avoid adverse selection. For example, if the group is large and undertakes to serve a whole area, it could receive a pooled payment from the insurance fund for all insured persons in the area. This payment according to number of persons, generally known as capitation, covers the well and the sick. Or, if the group prefers, it could be paid for the sick only, on a fee-for-service basis—so much for this service and so much for that. In either case, the group is protected against adverse selection.

Many variations and combinations are possible, depending on the nature of the group, what it is prepared and equipped to undertake, and the preferences of its membership.

Under any *method* of payment, the rate of payment and the amount paid to doctors should be adequate. This means adequate payments for general practitioner services and adequate payments for specialist services. The medical profession has a right to insist that the financial resources of a health insurance system shall be sufficient to pay adequately for high-grade services. Since the public would receive a larger amount of service with health insurance than without it, physicians as a whole would have a right to expect higher average incomes than they ordinarily receive.

In this connection, President Truman said:

> The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists, and nurses for the services they render.

Quality of care and freedom of profession.—Even ready access of the public to needed care and adequate payments to those who furnish care are not enough, of course. There are fundamental questions with regard to safeguarding the quality of care and continuing professional progress. On these questions it is more appropriate that the profession should speak than that I should, but I wish to offer a few observations.

By and large, it seems to me that quality of care should improve rather than decline if payment for service is guaranteed. It is alleged, however, that other characteristics of an insurance system will dominate the picture. And one hears about "regimentation" of doctors, "assignment of patients," "political control," and so on.

Everyone agrees, I believe, that the patient shall have free choice of doctor, and that the doctor shall be free to accept or reject patients. If the fee no longer stands between patient and doctor, the competitive relation between doctors will still remain, but it will rest on quality and adequacy of care. These are essentials for continuing good care. Where then are the issues?

One question concerns control over the professional aspects of medical practice. This is an ancient question—older than the Hippocratic Oath. Guidance, direction, supervision, discipline of doctors are primarily matters for doctors to handle. Subject to Government regulation through licensure, the responsibility has always been, and should remain, with the medical profession. No Government officer in his senses would take any other position. Just as public licensure gave the profession a new opportunity to deal with these problems, just as grading of medical schools, registration of hospitals, administration of workmen's compensation, and establishment of voluntary insurance plans—to mention only a few—gave the profession new opportunities to exercise professional controls, so inauguration of health insurance is still another step in the long evolutionary progress toward high ethical and qualitative standards. On this broad question, health insurance presents not a major threat but a new, great opportunity.

Another question is summarized in the phrases about "regimentation," "a czar over medicine," and the like. There is one sure way for the medical profession to see that what it doesn't want doesn't happen, even by inadvertence; that is to participate in planning the program. If it does, it will find itself working side by side with friends of the profession. There

is no problem here that can't be solved by men of good will.

Professional participation and program planning.—I hope I have succeeded in pointing out some of the essential differences between a system of State medicine and a system of health insurance. The first means a change from private medicine to public medicine. The second means changing from a pay-as-you-are-sick method to a prepayment method for spreading the costs of medical care.

However, even with this essential difference, it should be recognized that the medical profession has a justifiable concern as to the effect of a system of health insurance on the profession. The medical profession has a right to insist that the high standards of medical practice achieved in this country shall not only be maintained but also encouraged to advance as in the past. The medical profession has a right to insist that the doctor-patient relationship shall not be impaired in any way. It has a right to insist that its members shall be remunerated adequately for the services they render. Therefore, I believe that the medical profession should assist in developing legislation and should participate in the administration of the system that is enacted. I think it only fair to suggest, however, that organized medicine in this country should not give the impression of unqualified opposition to any governmental attempt to spread the costs of medical care.

Public Opinion Polls

Though hazards are involved in any governmental attempt to meet the problem of spreading the costs of medical care, I believe we must recognize that there is a large and growing demand by the people of this country that the Government act. Every unbiased poll that has been taken in the last 10 years shows that this is so.

As you know, the British Medical Association, as a result of more than 30 years of experience with health insurance, is wholeheartedly in favor of the principle of compulsory health insurance. Indeed, it has assumed leadership in demanding that the present health insurance system be made more comprehensive in terms of persons covered and services provided. Likewise, the Canadian Medical Association has gone on record as favoring the principle of compulsory health insurance.

Cooperation Between Medical Profession and Government

I hope that in this country, regardless of differences of opinion that may exist on general policies or on important details, the organized medical profession and the Government will join hands in undertaking to work out a constructive solution for the problem of assuring adequate health service for all the people. The Government needs the help of the medical profession in achieving this objective and, in my opinion, the medical profession also needs the help of the Government.

(*Continued from page 1*)

turn-over of employment and unemployment, the number of new claimants displaced, directly or indirectly, by returning veterans may be estimated at 75,000 to 100,000 a week—roughly, one worker was temporarily displaced for every four or five ex-servicemen returning to civilian occupation.

States which had been most severely affected by the first impact of the cancellation of war contracts in August and September showed appreciable improvement in work opportunities in November. The weekly number of claimants in Michigan declined from 229,000 in the week ended September 15 to 156,000 in the week ended November 24. The crest of unemployment has passed in Connecticut, New Jersey, and Pennsylvania, as well as in Massachusetts, Ohio, Illinois, Indiana, and Wisconsin. On the other hand, unemployment continued to rise in New York, the Pacific Coast States, and the South.

The increase in unemployment in the agricultural States is probably due, at least partly, to the return of workers who had left those States during the war when more promising jobs were available in industrial areas.

The conspicuous rise in unemployment in the West may be due to seasonal factors, the presence of migrant workers, and an influx of ex-servicemen. These factors, combined with the cancellation of war contracts, may create considerable pockets of temporary unemployment in the Pacific Coast States, despite the economic boom in this region.

The general trend is toward a more even distribution of unemployment over the country. The ratio of total weekly number of claims at the end of November to estimated covered employment as of December 1944 was 5.7 percent for the whole country as compared with 5.6 percent 2 months earlier. The rate of unemployment declined in the same period from 13.6 to 10.2 percent in Michigan; from 12.1 to 10.7 percent in New Jersey; from 9.4 to 7.5 percent in Connecticut; and from 7.2 to 5.9 percent in Illinois. It increased by more than 2 points in Alabama, Arkansas, Louisiana, Oklahoma, Oregon, and Washington, and by 1 to 2 points in California, Kentucky, Maine, Montana, Nevada, Tennessee, and West Virginia. Changes of less than half of 1 percent were recorded in Colorado, Georgia, Indi-

(*Continued on page 56*)

Weekly number of claimants for unemployment benefits, May 5–November 24, 1945