We cannot serve the people well through our own efforts alone. We cannot discharge our responsibilities as public administrators without the assistance of good people. We cannot hope to staff our agencies with good people unless we have adequate standards. We cannot content ourselves with selecting the "best of the worst." We must attract good people if we are going to be able to hire them. We must be able to choose the most competent among those who offer themselves for public service, and we must be able to equip them by training, not only for the sake of the public but for the sake of the employees themselves, to do an adequate and satisfactory job. If we attract, choose, and train good people but then lose them because we do not give them a sense of security in their jobs or a hope for advancement based upon quality of performance, we may later find ourselves in as bad a fix as we were when we started off.

The Decade Ahead

Amendments to the public assistance titles of the Social Security Act would be of immediate benefit to the States in this region. In the long run, however, universal coverage under the insurance system and expansion of the social insurances to include health insurance and protection against temporary and permanent disability undoubtedly would provide a greater measure of social security to the people of the Southwest. Adoption of the Board's recommendation of the inclusion of insurance against wage loss due to disability would relieve the States of a large part of the cost of general relief and would cut down needs for the special types of assistance. Fortunately we are not faced with an either-or proposition. We can—and I hope we will—have improvements in both the assistance and insurance programs early in this second decade of social security administration.

If we can look forward to as great progress in social security during the coming 10 years as we have seen during the last 10, and I think we can, we should enter this new period with hope and enthusiasm. The plans that are being put into effect in most of the other countries of the world illustrate, I believe, a universal demand for the achievement of our common aspiration for security. The attitudes of the people of this country have undergone a remarkable change during the brief period of social security administration here. Legislative changes may come more slowly here than some of us think desirable, but that they will come I have no doubt.

Need for a National Health Program: Excerpts From Testimony Presented Before the Senate Committee on Education and Labor

The Senate Committee on Education and Labor opened on April 2 comprehensive hearings on the National Health Act of 1945 (S. 1606). The following pages summarize statements presented to the Committee by the Federal Security Administrator, the Chief of the States Relations Division of the U. S. Public Health Service, and the Chairman of the Social Security Board.

ON NOVEMBER 19, 1945, President Truman transmitted to Congress his message on a national health program,[1] with the recommendation that "the Congress adopt a comprehensive and modern health program for the Nation." Immediately afterward, S. 1606, the National Health Act of 1945, proposing a program "along the lines set forth by the President," was introduced by Senator Wagner, for himself and Senator Murray. A companion bill, H. R. 4730, was introduced in the House by Representative Dingell. In a report on the bill (Senate Committee Print No. 1, November 26), Senator Wagner summarized its major provisions: broadening and increasing the present Federal grants-in-aid to the States for public health services, to speed up the progress of preventive and community-wide health services; a similar increase in the community-wide maternal and child health services which are aided by Federal grants to the States; authorization of Federal grants to States for meeting the costs of medical care for needy persons; prepaid personal health service benefits, based on need for services rather than on ability to pay; and, in connection with the provision of prepaid medical care, grants-in-aid to nonprofit institutions engaging in research or professional education.

The Senate bill was referred to the Committee on Education and Labor, which began hearings on the bill on April 2. On April 3, Watson B. Miller, Federal Security Administrator, told the Committee that, individually and as spokesman for the Agency, he stood squarely behind the national health program, which he characterized as necessary, practical, and long overdue. The program, as outlined by President Truman and as proposed in S. 1606, appeared complex, he said, because it was necessarily comprehensive, covering the entire Nation and dealing "with an aspect of our common welfare in which our day-to-day practice has lagged far behind our standards, our knowledge, and our resources." In reality, he asserted, the basic issue is simple. "The health of the people is the strength of the Nation. Health protection, for himself and his family, is implicit in the guarantees which the American democracy makes to every citizen. As a fundamental need of all the people, health is a proper responsibility of the national Government, as of the State and local governments. To help meet this need, Government has a twofold task—first, to provide, insofar as possible, a healthful environment, to see that the communities in which people live are free from the needless threat of disease-breeding hazards; second, to assure to every individual safeguards against the

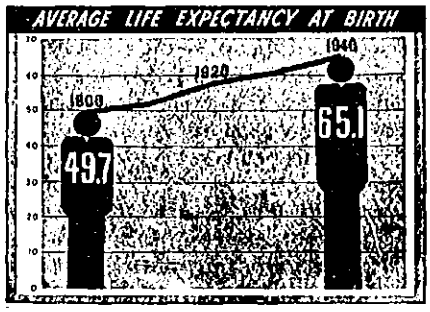
[1] See the *Bulletin*, December 1945, pp. 7–12.

manifold and universal disasters which illness may entail."

The measures proposed in the bill under discussion are "the core of such a program," Mr. Miller declared, "but they can be considered in their true proportion only as we bear constantly in mind their integral relationship with other segments of the over-all plan . . . embodied in other measures now before the Congress—the hospital construction bill, the mental health bill, and the provisions for compensating against wage loss resulting from temporary or permanent disability."

As other representatives of the Federal Security Agency, Dr. Joseph W. Mountin, Chief of the States Relations Division of the U. S. Public Health Service, presented his statement on April 3, and Arthur J. Altmeyer, Chairman of the Social Security Board, testified the following day. Mr. Altmeyer explained that the Board's interest in national health "is fundamental to its responsibility under law for administering social security programs and for 'studying and making recommendations as to the most effective methods of providing economic security through social insurance. . .' Health is basic to the security of the men, women, and children—the families—of America. Sickness and premature death are among the most important causes of insecurity. . . Protection against the costs and the losses that follow upon sickness is an integral part of social security."

The proposed program has the endorsement of the Public Health Service, Dr. Mountin told the Committee, because it is "designed not only to strengthen present programs, but to supply the missing link of personal health services." Its "fundamental premise is that ready access to health service and medical care is not a luxury to be bought only by those who can pay, but the right of every American—wherever he may live and whatever he may earn. Unlike most previous health legislation proposals, therefore, this bill does not confine itself to a single facet of our national health problem. Instead, its sponsors have taken the broad measure of our health needs as a whole and have boldly proposed action designed to meet these needs. . .



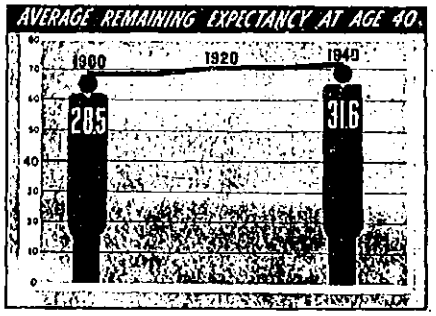
"As the Federal agency primarily responsible for the protection and promotion of the Nation's health, the Public Health Service believes that public recognition of this goal of good health service for all our people is long overdue. We further believe that this goal is within our power as a Nation to achieve as soon as a program is adopted which is based on a forthright appraisal of needs."

National Health Needs

"All of us—laymen and medical men alike," Dr. Mountin continued, "derive a large measure of satisfaction from reviewing the progress made to date in the battle against disease and preventable death.[1] Through the combined efforts of scientists, medical practitioners and public health officials, the average life expectancy at birth has been steadily extended from 49.7 years in 1900 to 65.1 years today . . . we all have reason to be proud of these accomplishments. But I am afraid many people are prone to assume that these favorable trends have some magic capacity to project themselves automatically into the future, and that time alone will extend the conquest of disease.

"Unfortunately . . . improvement in life expectancy at birth has not been paralleled by a corresponding improvement in the expectancy of persons who have reached the age of 40. In fact . . . the average life expectancy of most of us here today has increased very little over that of our grandfathers in 1900, even though babies born today have a much greater expectancy than those of us born around 1900.

"The age factor in life expectancy is particularly important when we recall that our national population as a whole is becoming older. In 1900, 1 person in 25 was 65 years of age or older; today, 1 person in 15. By 1980, the ratio will be 1 to 10. At our present rate of progress, more babies will live to maturity, but the years of maturity will be extended only slightly, if at all. This conclusion is partly explained by a comparison of diseases which have already been brought under control with those for which the death rate is increasing."



Dr. Mountin cited the reduction and, in some cases, virtual elimination of certain diseases since 1900, largely as a result of new scientific knowledge applied through organized programs of mass prevention or treatment. Typhoid fever, diarrhea and enteritis, malaria, and yellow fever were conquered by environmental sanitation; diphtheria and smallpox by immunization; pellagra by nutrition; and tuberculosis is now being steadily overcome through programs for the early discovery, isolation, and treatment of the disease. It is largely through progress in control of such diseases that the life expectancy for people under 40 has been so strikingly improved.

On the other side of the ledger, he pointed out, are diseases which are accounting for an ever increasing number of deaths. The death rate from cancer in 1943 was almost double that of 1900. More than twice as many people died from diabetes in 1943 as at the turn of the century. Despite the great progress made in many fields of medical science, 23 persons in 1943 succumbed to heart disease to every 10 in 1900. In addition, arthritis, rheumatic fever, peptic ulcer, hypertension, and nephritis continue to take a heavy toll in disability or death.

The increasing death rate for these diseases, most of which strike men and women in the peak productive

[1] The charts used here were prepared by the Public Health Service and presented at the Committee hearings.

years of life, is the principal reason why so little improvement has been made in the average life span of people in the older age groups.

If any significant progress is to be made in this health area, Dr. Mountin asserted, means must be developed for ensuring the application of present scientific knowledge to the control of diseases of maturity. This does not mean, however, that we can apply the traditional public health techniques of control to this disease category. Unless medical research reveals some new methods of attack—and probably even then—the only effective means of helping the victims of these diseases is to provide them with adequate medical care through full personal health services. Even without specific preventive measures, much can be done to reduce the severity of these diseases and their disabling effects by ensuring that their victims could have the full benefits of present medical knowledge and skills. Early diagnosis and treatment would in many cases prevent serious developments, and in every case would at least minimize or postpone the disabling effects of these diseases.

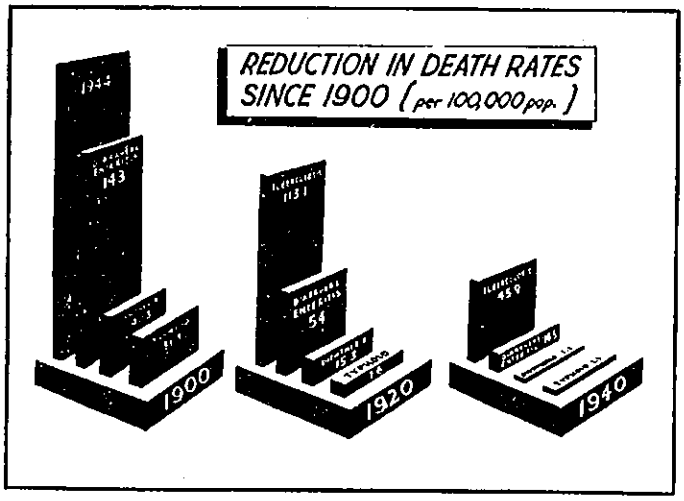
He did not want to give the impression, Dr. Mountin continued, that the need for a medical care program is based entirely on the health needs of people over 40 years of age. Rheumatic fever, for example, remains a major health hazard of the young. So do appendicitis, pneumonia, and poliomyelitis. It is only through the provision of adequate medical care on an individual basis that it will be possible to reduce the harmful effects of these diseases. Adequate medical care for all people—old and young alike—must be the cornerstone of any program designed to meet the health needs of the Nation.

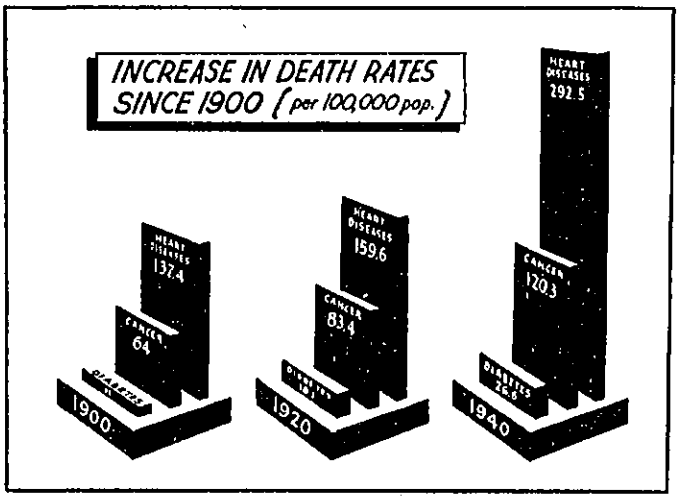
Even this brief review of the Nation's health needs, Dr. Mountin pointed out, should serve to illustrate the need for a comprehensive and closely coordinated national health program. No single method or approach will do the job. Great medical advances have been made through scientific research, but scientific discoveries must be brought to all those who need them before they can be completely effective. It has been proved that mass attacks through traditional public health techniques can reduce some diseases to insignificant proportions. But such programs still leave a broadening sector of the disease front to be attacked through improved medical care—by personal health services as contrasted with mass services. Unless we solve the basic problem of providing adequate medical services for all who need them, the effectiveness of preventive health services, of research and education, and indeed of widespread hospital and health center construction contemplated under other legislation, will be limited.

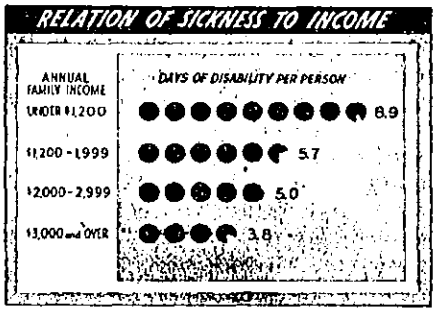
Barriers to Adequate Medical Care

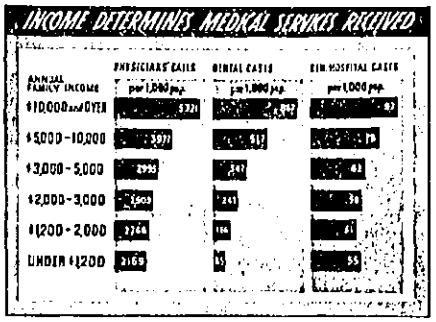
We must face the fact, Dr. Mountin continued, that a highly inequitable cash barrier now keeps medical care from millions of our citizens. Despite the frequently unrewarded service of physicians to the poor and the excellent provisions of many public welfare medical programs, the private family-by-family system of paying for medical services means that, on the whole, only those services can be obtained which the family is, at the time, in a position to pay for. As a result, we find that medical services received bear only a casual relationship to health needs. The lowest income groups, among whom illness occurs with greatest frequency and longest duration, actually receive the smallest volume of medical services. It has been stated that "the rich and the poor get adequate medical care and only the middle income group suffers." Nation-wide studies conducted under the technical supervision of the Public Health Service do not bear this out. They show that medical services follow the call of the dollar sign with unfaltering consistency, while disease and disability strike in the opposite direction. As measured in terms of days of disability, the burden of illness falls most heavily on persons in the lower income categories. But, although their needs are the greatest, persons with low incomes do not receive their share of medical services. In fact, the benefits of doctors' and dentists' services, as well as hospital care, depend upon the income of those who are in need of care. In other words, medical care in the United States today is a matter of being able to pay the price.

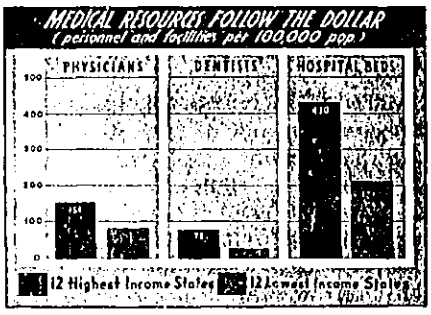
Much of the difficulty in obtaining needed medical care, Dr. Mountin continued, is related not merely to inadequate income, but to the inability of an individual or family to budget for medical costs. In all in-











come groups, medical costs strike highly unevenly. In any one year, medical expenses appear to constitute no overwhelming problem to a majority of families; an unfortunate minority, however, are crippled with high medical costs. In which group any family will fall cannot be told at the beginning of a year. It is, therefore, practically impossible to budget on a family basis.

Another unfortunate consequence of this relationship between purchasing power and medical services is the serious maldistribution of medical resources among different sections and communities. In other words, people who live in areas of high average income have more medical personnel and facilities to serve them than the people who live in low-income areas.

Because service has depended primarily on individual or family ability to pay, it has been natural and inevitable for physicians to settle in areas where local purchasing power has been most ample, where their skills could be most fully utilized and they could make the best living. The same has applied to dentists and other health service personnel. The maldistribution of medical resources has been especially pronounced between the cities, with their higher average income levels, and the rural areas, with their lower average income levels. As the costs of medical care or, put in another way, the costs of financing the skills of physicians, have risen, this maldistribution has grown increasingly more severe. Hundreds of counties throughout our country today are supplied so poorly with doctors that millions of people in them are simply unable to get medical attention in time of need. What is more, there are no signs of improvement, and the pattern of settlement being elected by thousands of physicians and dentists leaving the armed services is serving further to exaggerate present disproportions. There seems to be no prospect of solution of this crisis facing rural areas, unless steps are taken toward equalizing the financial support for medical services in all parts of the Nation.

Likewise, there has been a natural tendency to build hospitals in areas where they can be best utilized and financially maintained. As a result the disproportions in the supply of hospital beds between areas are no less severe than those relating to physicians. Other legislation receiving the attention of the Congress is designed to correct some of these deficiencies, but it is clear that—no matter how many structures may be built—hospital services cannot be made available to people in relation to their needs without a pooling of resources.

On a Nation-wide basis, Dr. Mountin declared, the costs of medical care would be related to ability to pay, and services would be provided in accordance with health needs. Administrative costs would be lower; payments for professional services would be more ample. There would be equitable spreading of funds between areas of varying wealth. Rural sections, with their generally lower income levels and their greater medical care needs, would be particularly benefited. The scope of health services would be considerably broader and the quality more uniformly high.

Passage of a national health bill would not, of course, create adequate medical care for all persons overnight. It would, however, make immediately accessible to all insured persons the medical personnel and facilities at hand in their communities. More important, the medical services furnished an individual would be determined by his need of them and not by his bank balance.

Moreover, such a program would go a long way to encourage a better distribution of physicians and dentists around the Nation. Existing institutions as well as institutions to be built under the proposed national hospital construction program would be assured of proper financial maintenance. Medical and allied personnel would no longer have to concentrate in larger cities to make a living, and the people of our great rural districts would become supplied with their fair share of doctors and other health workers.

Experience With Voluntary Plans

Both Mr. Altmeyer and Dr. Mountin discussed experience in attempting to meet medical care problems through voluntary prepayment plans. "The crucial test of a health insurance program," Mr. Altmeyer pointed out, "is not its good intentions, but the population coverage it achieves and the scope of protection it furnishes." The limitations of the voluntary approach were summarized by Dr. Mountin as follows:

Voluntary insurance plans in this country vary considerably as to the form of benefits provided to their members. Some reimburse the patient in cash for all or part of specified medical expenses; others provide benefits in the form of direct services. The scope of benefits varies even more. Some plans cover hospital services only, while others include one or more categories of medical, dental, or nursing benefits. All contribute toward easing the economic burden of illness, but all suffer from numerous inherent shortcomings.

First of all, the premiums charged by voluntary plans for anything approaching comprehensive services are too high for persons in the lower income groups—the very persons needing protection most. With few excep-

tions, premiums or membership fees are based on scope of benefits, with little or no adjustment for families in different income brackets.

Second, to guard against unfavorable risks, voluntary plans have found it necessary to restrict their services in many ways. While benefit provisions vary from plan to plan, all exclude care for some type of illness. Most common among these exclusions are treatment of conditions which existed before enrollment, chronic sickness, maternity care during the first 10 months of membership, home calls, nursing care, and dental service. Thus, many vital health needs are not met through the services provided by voluntary plans.

Third, the development of voluntary health insurance plans on a community, county, or State basis tends to limit the scope and content of services in proportion to the average per capita wealth of that area. A voluntary prepayment plan developed in a poor rural community could never offer its members the range or quality of services of a plan developed in a wealthy metropolitan area. Voluntary plans provide no mechanism for equalizing the capacity of different areas to support necessary medical services.

Fourth, because of their small-unit operation and the recurring task of "selling" plan memberships, most voluntary plans incur relatively high administrative costs.

These contentions are not mere theory, Dr. Mountin continued. We may look at the actual record of voluntary health insurance in the United States and abroad. In practically every other industrialized nation, the development of voluntary health insurance plans has served as a prelude to the establishment of compulsory insurance programs—not because the voluntary plans did not perform a useful function, but because they did not perform service of sufficient scope for enough people and for those who need service most.

In the United States, he declared, the most successful application of the insurance principle has been with respect to hospitalization. From its beginning 17 or 18 years ago, the most extensive group hospitalization movement has grown rapidly to cover about 20 million persons. Despite the unprecedented economic prosperity of the last few years, however, membership in these plans is largely concentrated in a few industrialized States and some 85 percent of our population remains without this hospitalization protection. Moreover, the insurance protection offered under this program encompasses hardly more than 15 percent of the total medical care bill of the average American family.

As for comprehensive medical care insurance, experience in this country so far gives even less reason to be sanguine for a significant future expansion. Despite a history that dates back to the nineteenth century, insurance for anything approaching general medical and hospital services—rarely indeed including dental care, home nursing, or other special items—encompasses less than 3 percent of our national population.

All these considerations, Dr. Mountin declared, have led the Public Health Service to the conclusion that only a Nation-wide program of medical care, under official auspices, holds the promise of assuring adequate medical care for all the people.[3]

Compulsory Insurance

The greatest value of voluntary health insurance, Mr. Altmeyer told the Committee, has been the experience gained in learning how to operate compulsory prepayment plans. By a study of the accomplishments of voluntary insurance and the difficulties it has encountered, a program can be worked out which can succeed where voluntary plans have failed.

The principal reason why voluntary programs have not succeeded, and cannot succeed, is economic. Unless adequate funds are available, no program can adequately extend either its membership or the scope of its services.

A comprehensive health insurance program must rest on a method of financing which makes it possible for the family to budget the costs without having to deny itself the essentials of everyday living. The costs must also be distributed among a membership that is large enough to keep the premium low and in accordance with ability to pay. To accomplish these ends, compulsory insurance is necessary.

Compulsion is not a word that is accepted lightly by the American people, and the opponents of compulsory health insurance have made much of this natural antipathy.

The American Medical Association and other organizations favoring the present inadequate voluntary plans or sponsoring new voluntary insurance programs have implied that a compulsory system of health insurance would result in regimentation and a form of totalitarianism which is not in keeping with the principles expressed in our Constitution and in the Bill of Rights. However, it might be pointed out that voluntary insurance, as advocated by the American Medical Association, is anything but democratic. The AMA recommends a series of voluntary plans, to be run by the medical societies. No mention is made of other associations or of public participation in the organization of these plans, in the control of the funds which the public will have to pay, in the formulation of the standards the plans will observe, or in their administration. The Association violates the first principle of democracy—the right of the public to participate—to say nothing of the right of the public to control public enterprise essential to the welfare of the public.

In contrast, under compulsory health insurance, financing and administration would be determined by representatives of the public—using the advice and the skills of professional groups on professional matters. That may be why the public attitude toward health insurance as a part of a system of social insurance is so favorable, as evidenced by many polls of public opinion. The Gallup Poll of 1943 showed 59 percent of the persons canvassed in favor of a compulsory health insurance plan. A public poll was taken a few months ago for and at the expense of the National Physicians' Committee, the spearhead organization attacking the bill we are discussing. That poll showed that 64 percent of the people prefer a prepayment method for meeting med-

[3] See also the conclusions and recommendations contained in a report on the Department of Agriculture's experimental rural health program, pages 40–43 of this issue.

ical costs and that 55 percent think a Federal plan would be a "good thing for the Nation as a whole." In January of this year, a poll taken throughout New York State by the New York State Commission on Medical Care showed that 86 percent of those questioned favor an insurance system and 52 percent favor a compulsory governmental system. In the District of Columbia, according to a survey made a few months ago by the *Washington Post*, an overwhelming majority—70 percent—of the residents favor President Truman's proposals for a compulsory health insurance program.

Mr. Altmeyer also spoke of the increasingly strong public support for compulsory health insurance which, he believes, is based in large measure on a recognition of the responsibility of a democratic government to assure that the health of the people is safeguarded and improved to the utmost extent that medical science and our resources make possible.

Government already carries large responsibilities for health and medical services. In 1944, governmental expenditures—Federal, State, and local—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.

It should also be noted that this country already has in effect a system of compulsory health insurance covering the cost of medical care for work-connected disabilities—namely, workmen's compensation. General health insurance merely extends the principle to include disability not arising out of employment.

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.

A National System of Health Insurance

In discussing a national system of health insurance, Mr. Altmeyer stressed the fact that, to be adequate and successful, health insurance must make it possible for everybody to have ready access to adequate medical care, both preventive and curative. If this cannot be achieved from the outset, the program that is adopted should lend itself to growth, with national coverage as the goal. To the greatest extent practicable, care should be provided for the dependents of insured workers on the same basis as for the worker. As far as practicable, the insurance program should be extended by supplementary agreements or otherwise to cover all noninsured groups who are in need of protection. All existing medical personnel and facilities meeting reasonable standards that wish to participate should be utilized to the maximum degree, and the remuneration for services should be adequate. The quality of service must not be sacrificed to economy. Both physician and patient should be assured freedom of choice. Professional groups, as well as the public, should participate in determining policies. Adequate provisions should also be made to stimulate professional education, research, and the prevention of disease and disability.

A program of this scope will require sufficient medical personnel and facilities to provide comprehensive services, and these must be located throughout the country in a manner which will make services available to everyone. The program will have to encourage the training of needed personnel and the construction of needed facilities. The cost of such a program must be broadly distributed over groups in the population. The system must be so designed as to provide benefits to the insured regardless of his individual ability to pay and where he is residing at the time he is in need of services.

These, Mr. Altmeyer declared, are the main criteria by which an American plan for prepayment of medical costs should be judged.

To achieve the goals, a national health insurance system has many advantages over 51 State and Territorial systems—such as may result from State-by-State action. A national system would encourage better distribution of professional personnel among the States as well as within States, and the construction of needed facilities. It would avoid the problems that result from the grossly unequal economic resources of the States for the support of health services, so that at least a minimum standard of adequacy can be achieved within a reasonable period of time in all States and in all communities. It would assure maintenance of continuity of insurance protection and ready access to services despite the mobility of population across State lines. It would achieve the administrative economy that results from avoiding the need to maintain and identify separate State-by-State records for such persons. It would be freely able to use natural medical and hospital service areas, regardless of State lines. It would escape the competitive disadvantages for States that establish social insurance systems as against States that do not.

Every State that has considered the establishment of a social insurance system has shown itself reluctant to act by itself. The Congress faced this problem in 1935 when it was first considering the original Social Security Act; and it concluded at that time that Federal action was needed to set up a national system of social insurance and to make State action possible for the establishment of State systems.

The logical, the efficient, and the economical way to have a national system of compulsory health insurance is to establish a truly national system.

Mr. Altmeyer pointed out that a national health insurance system with national benefit provisions can still be highly decentralized in actual operation. People will ordinarily receive care in the communities where they live; doctors will ordinarily find it most convenient to submit their bills to a local health insurance office. Provision should be made—and under the bill, can be made—for the maximum possible adaptation to local practices and methods of obtaining service, within the over-all standards of the national program.

He also expressed cordial agreement with proposals for the use of advisory councils, including representation of the public and the medical profession, "at every level of administration." It is sound to call upon the medical profession for advice on policy matters relating to the administration of the program. Representa-

(Continued on page 31)

Monthly Benefits and Lump-Sum Payments Awarded, January–March 1946

During the first quarter of 1946, more than 147,000 monthly benefits were awarded (table 6), an increase of 10 percent over awards in the preceding quarter and of 41 percent from those in the first quarter of 1945.

Awards of primary and wife's benefits outnumbered those in any previous quarter. The number of these awards has increased greatly since the cessation of hostilities, as many older workers lost their employment and filed for benefits. Primary benefits awarded during the first quarter of 1946 were more than double the number awarded during the first quarter of 1945.

For all types of survivor benefits except parent's, the number of awards was somewhat larger than during the preceding quarter. Awards of survivor benefits are generally more numerous at this time of year because of high mortality rates during the winter months. The number of widow's current and child's benefits awarded was considerably less than in the first and second quarters of 1945, however, with the drop in claims arising from war deaths.

Awards of lump-sum death payments increased 13 percent over those in the preceding quarter but were less than in the first 2 quarters of 1945.

Table 6.—*Number of monthly benefits and lump-sum death payments awarded, by type of benefit and by quarter, 1940–46*

[Corrected to Apr. 17, 1946]

Year and quarter	Monthly benefits							Lump-sum death payments[1]
	Total	Primary	Wife's	Child's	Widow's	Widow's current	Parent's	
1940								
Jan.–Mar.	40,780	28,211	4,366	5,078	168	2,057	0	7,046
Apr.–June	67,824	33,055	8,468	17,408	885	6,885	223	19,074
July–Sept.	76,113	38,245	11,981	17,220	1,560	6,782	325	23,793
Oct.–Dec.	70,267	31,924	9,740	18,776	1,087	7,536	304	25,182
1941								
Jan.–Mar.	74,567	32,802	9,901	20,597	2,703	8,227	337	30,633
Apr.–June	66,074	28,879	8,962	18,021	2,617	7,278	317	28,210
July–Sept.	65,593	27,238	8,898	18,745	2,786	7,632	294	29,610
Oct.–Dec.	63,052	25,741	8,452	18,256	2,914	7,365	324	28,850
1942								
Jan.–Mar.	68,181	27,609	9,161	19,596	3,505	8,027	283	33,410
Apr.–June	67,679	26,878	8,649	19,991	3,690	8,134	337	35,428
July–Sept.	62,161	23,826	8,013	18,894	3,475	7,624	329	32,032
Oct.–Dec.	60,095	21,309	7,427	18,903	4,104	8,035	317	33,221
1943								
Jan.–Mar.	67,750	23,754	8,112	21,503	4,975	9,078	328	40,525
Apr.–June	69,757	23,803	8,372	22,811	5,051	9,387	333	43,108
July–Sept.	63,501	21,378	7,806	20,764	4,695	8,476	202	39,485
Oct.–Dec.	61,857	20,135	7,536	20,541	4,855	8,479	311	39,893
1944								
Jan.–Mar.	75,807	25,474	9,401	23,978	6,416	10,225	313	47,342
Apr.–June	79,003	27,907	10,150	24,442	6,086	10,067	351	48,970
July–Sept.	78,976	27,607	10,066	24,589	5,804	10,559	351	52,444
Oct.–Dec.	85,163	29,109	10,732	26,667	6,453	11,798	404	56,416
1945								
Jan.–Mar.	104,064	35,613	12,587	33,025	7,730	14,689	420	65,695
Apr.–June	117,857	41,116	14,454	37,208	7,954	16,614	511	69,770
July–Sept.	106,782	44,493	14,908	28,058	6,821	12,096	406	54,750
Oct.–Dec.	133,766	63,950	21,131	29,218	7,337	11,711	410	56,797
1946								
Jan.–Mar.	147,236	72,381	23,554	30,092	8,805	12,006	395	64,182

[1] Under 1939 amendments.

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tives of the persons receiving services and representatives of the public also have an essential role in the administration of a public program.

Medical Care of Needy Persons

Mr. Altmeyer also endorsed the proposals for special arrangements to provide medical care for needy persons through Federal participation in financing arrangements devised by State public assistance agencies.

Sickness causes suffering and economic loss among all people, but it affects certain groups of people more than others. Among low-income families and people on the assistance rolls, illness comes oftener and lasts longer, on the average, than among others. Medical care is especially important to these persons not only to prevent or cure sickness but also to reduce dependency.

The three groups of needy persons covered by assistance programs under the Social Security Act are likely to have especially heavy medical needs since they are old or blind or are children in dependent families. Larger-than-average medical needs likewise exist among the group served by general assistance, which is financed wholly by the State or locality or both, without Federal financial participation.