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CHAPTER I

INTRODUCTION

For years the United States lagged far behind many European nations in protecting the health of its mothers and children. Generally speaking, the public was unaware of the high infant and maternal mortality rates that existed and felt little could be done in any case to prevent them. There were many persons who believed that to save the lives of those unfortunate mothers and infants would interfere with the "natural" process of evolution. Furthermore, fear of government intervention and interference in local matters prevented the appropriate state and federal agencies from aiding many of these individuals.

Only at the close of the nineteenth century did the concept of providing health services for mothers and children as a public responsibility develop. Nathan Straus first established "infant milk depots" in New York City in 1893.¹ This project provided bacteriologically clean milk to children, and mothers were educated in preparing infant feedings and in child care at these "infant milk depots." This was followed soon by similar efforts in other parts of the country.²

These initial efforts under voluntary auspices provided the initial impetus for government action. As early as 1897, Rochester New York Health Department established two milk stations and employed physicians and nurses in an effort to reduce the incidence of infant death from diarrheal illness.³
Boston initiated the first systematic inspection of school children for evidence of communicable diseases in 1897 with the appointment of a physician and nurse in each school district. Other cities soon followed Boston's lead with Chicago and Philadelphia taking action in 1895 and New York in 1897. New York City established the first bureau of child hygiene in a city department of health in 1908. This bureau set the pattern for a general attack on child and maternal health problems by local and state health departments. Louisiana became the first state to establish a division of child hygiene in a state department of health in 1912. Between 1912 and 1917, seven more states provided state divisions for child hygiene.

At about the same time, public aid for crippled children became available at the state level. In 1897, Minnesota enacted the first state statute providing for free medical and surgical treatment for cripples to be given at the State University Hospital. Two years later New York created at West Haverstraw the first separate state institution strictly for indigent cripples. The New York statute was used as a basis for laws creating state institutions during the period 1910-1927 in Nebraska, Massachusetts, North Carolina, Minnesota, and Pennsylvania. By 1914, public day schools for crippled children had come into being in the public school systems of four large cities. New York and New Jersey were the first to give statutory support to special education for physically handicapped children. In 1917, the New York law required school districts with ten or more deaf, blind, crippled or otherwise physically defective children to maintain special classes for their education. New Jersey followed the next year with a
law providing financial aid for transportation and teachers salaries.\textsuperscript{10}

It was not until the establishment of the U.S. Children's Bureau in 1912 that special federal emphasis on child and maternal health began. Prior to this, the U.S. Public Health Service had conducted the only federal activity related to maternal and infant welfare. In 1909, the Public Health Service conducted a study of the relation of contaminated milk to infant mortality.\textsuperscript{11} As early as 1903, Miss Lilian Wald, a public health nurse and founder of the Henry Street Settlement House in New York City, had suggested the creation of a separate federal bureau for children.\textsuperscript{12} Congressional recognition of the need for a special bureau devoted to the interests of children first came in 1906 when Senator Winthrop M. Crane, Republican from Massachusetts, and Representative Augustus P. Gardner, Republican from Massachusetts, introduced bills to establish a Children's Bureau in the Department of the Interior.

President Theodore Roosevelt expressed his interest in child welfare when he called the first White House Conference on the Care of Dependent Children (1909). When the Conference adjourned, President Roosevelt endorsed one of their recommendations—the establishment of a children's bureau. Toward this end he sent a special message to the Congress.\textsuperscript{13} President William Howard Taft also urged the enactment of the Children's Bureau bill. Opponents challenged the constitutionality of the bill, holding that the responsibility for children's health and welfare were solely that of the states. Senator William E. Borah, who introduced the bill which was finally enacted in 1912, granted that 50 years earlier the problems of the children could well be left to the
states, but "economic conditions have changed and the responsibilities and duties of government must necessarily change with those changes." After three years of sometimes heated debate, the bill passed the Senate by a vote of 54 to 20 and in the House by a vote of 177 to 17. The bill was signed into law by President Taft on April 9, 1912. Julia Lathrop, a social worker with Jane Addams at Hull House, became the first Chief of the Children's Bureau with initial funding of $25,000 and a staff of 15. In 1913, the Children's Bureau became a branch of the newly created Department of Labor after the division of the Department of Commerce and Labor into two separate departments.

Under the terms of the Organic Act, the Children's Bureau was established primarily as an investigatory and reporting agency on "all matters pertaining to the welfare and child life among all classes of the people," and especially "to investigate the question on infant mortality... The Chief of said bureau may from time to time publish the results of these investigations in such manner and to such extent as may be prescribed by the Secretary of Commerce and Labor." The first concern of the new Children's Bureau was to conduct an intensive study of the causes of infant mortality. Infant mortality had never been specifically considered as a social study, so a new type of study was undertaken. Infant mortality was studied from birth records and through the first year of life, instead of from death records. Careful attention was given to the social, civic, and industrial conditions of the families, as well as complete history of the baby's growth with special emphasis on feeding habits. Johnstown, Pennsylvania was selected as the first site of the study. Subsequently,
nine other industrial cities were selected for study as well as 12 rural communities in the South, Middle, and Western parts of the United States. In this fashion the project was able to ascertain the care available to mothers and infants in locations as far separated as Akron, Ohio, Gary, Indiana, and Baltimore, Maryland.21

It was discovered that infants were not the only victims of lack of proper health and care. Mothers were also dying and in such great numbers that the maternity death rate in the United States had increased rather than decreased.22 In 1917, the Children's Bureau published a pamphlet written by Grace I. Meigs: Maternal Mortality From All Conditions Connected with Childbirth in the United States and Certain Other Foreign Countries.23 This was the first attempt by the federal government to awaken the country to the serious risks which pregnant women faced. Miss Meigs declared that the maternal mortality rate could be sharply reduced with adequate prenatal and antepartum postnatal care of the mother.

All these studies indicated that high infant mortality rate coincided with poor housing, low wage earnings, large families, and the employment of the mother outside the home. A significant variation was discovered in the infant mortality rates in different areas of the United States and among varying racial groups. These studies brought the startling lack of medical and nursing care for mothers in many sections of the country to the attention of the nation and showed that the greatest proportion of infant deaths were preventable with good medical care.

The Children's Bureau studies led directly to a number of
activities--a campaign to increase birth registration, carried on in cooperation with the U.S. Bureau of Census and the assistance of the General Federation of Women's Clubs; the issuance in 1914 of the first edition of the pamphlet "Infant Care," which became the prototype for future books issued by the Bureau, and the nation-wide observance of Baby Week in March, 1916, in which 2,083 communities participated.\(^\text{24}\)

The Children's Bureau assembled and interpreted figures previously published by the Bureau of Census relative to infant and child mortality. Data were also collected on methods for reducing infant mortality. They included the instruction of mothers through infant welfare centers, the role of the public health nurse, and popular bulletins concerning the proper care of children, the importance of consulting a doctor upon the first discovery of pregnancy, and the value of breast feeding.

By 1917, the Children's Bureau had marshalled a considerable body of social and economic as well as medical facts related to the causes of maternal and infant mortality. Miss Julia Lathrop, the first Chief of the Children's Bureau, embarked on a campaign to bring these facts before the public. From 1918 to 1921, a long and arduous campaign was carried on largely by the Bureau to inform women about the high infant mortality rates and the type of federal-state action that should be initiated to reduce them.

In 1918, the Bureau, in cooperation with the Women's Committee on the Council of National Defense, announced the second year of involvement in the First World War as Children's Year. The program for Children's Year (April 6, 1918 through April 6, 1919) involved a
national campaign to reduce infant mortality by saving the lives of 100,000 children. In order to carry out this program, local committees were organized in 46 states. The drive was opened with the weighing and measuring tests of approximately 7,000,000 preschool children in more than 16,500 cities, towns, villages, and rural communities. Where it was possible children were given free medical examinations. These Children's Year activities revealed that many children suffered from preventable and remedial defects.

During the war, the federal government took a significant step in the care of the handicapped with the passage of the Smith-Sears Act of 1918, which created a rehabilitation service for disabled soldiers. An unsuccessful attempt was made to include aid to children in it. On June 2, 1920, the Fess-Kenyon Bill became the first federal law supplying aid for the civilian physically disabled, including service to veterans in civilian capacity. The appropriation for the first year was $750,000 and for the next three succeeding years $1,000,000. States were required at least to match their respective federal quotas. These Acts—Smith-Sears Act of 1918 and Fess-Kenyon Act of 1920—established for the first time the federal-state services to meet the needs of certain handicapped persons and set a precedent for federal aid to crippled children.

The Second White House Conference on Children was held in Washington as the concluding activity of Children's Year. It convened on May 5 through 8, 1919, at the request of President Woodrow Wilson, with funds supplied from the war emergency fund. The Children's Bureau handled organization with five areas under study: the economic
and social basis for child welfare standards, child labor, children in need of special care, standardization of child welfare laws, and the health of children and mothers. Minimum standards on child health and welfare were formulated at the Conference and later revised by eight regional conferences, beginning with one in Washington on "Standards of Child Welfare." The reports of the regional conferences included the first substantial series of proposals for standards of programs for the health of mothers and children.

These initial studies of the extent and causes of infant and maternal mortality indicated the pressing need for a national program to provide protection for these individuals. In her 1917 Annual Report Miss Lathrop, Chief of the Children's Bureau, called for a nationwide program that would provide public health nurses and instruction in schools and universities, covering the field of hygiene for mothers and children. Miss Lathrop also advocated conference centers for healthy children, adequate confinement care for pregnant women, and improved hospital facilities for mothers and children. To accomplish these objectives she proposed that the federal government make grants to the states for maternal and infant "protection," to be distributed in local areas where investigation showed the need, and where "contributions are duly authorized from state and county funds in such proportions to the federal fund as may be determined." Miss Lathrop cited the Smith-Lever Act of May 8, 1914, as a precedent for such aid to rural mothers. Under this law, federal money was appropriated for rural home demonstrations in agriculture and home economics, provided that the cooperating states matched the federal funds equally. Miss Lathrop renewed
the recommendation in favor of this use of federal aid in 1918 and 1919.

On June 29, 1918, Miss Jeanette Rankin, the first woman member of Congress, introduced in the House a bill, drafted largely by the Children's Bureau, to implement Miss Lathrop's suggestion. Over the succeeding three years amended versions of the bill received increased attention until the final version was re-introduced by Democratic Senator Morris Sheppard of Texas and Republican Congressman Horace Towner of Iowa in the Sixty-sixth Congress.

The Sheppard-Towner bill had the endorsement of an impressive list of organizations including the National League of Women Voters, the American Child Hygiene Association, the National Conference of Catholic Charities, the General Federation of Women's Clubs, the National Women's Christian Temperance Union, and the Continental Congress of the Daughters of the American Revolution. The opponents of the bill included the New York Anti-Vivisection Society, the National Society for Human Regulation of Vivisection, the Citizen's Medicine Reference Bureau, the American Medicine Liberty League, and the Maryland Association Opposed to Women Suffrage, and the American Medical Association. The Democratic platform in 1920 came out in support of the bill. The Republican platform ignored the bill, but Warren G. Harding firmly committed himself to the measures in his Justice Day speech on October 1, 1920.

The Sheppard-Towner Bill was assailed and opposed in Congress as "socialistic," and denounced as "drawn chiefly from the radical, socialistic, bolshevistic philosophy of Germany and Russia."
opposition the bill finally passed the Senate on July 22, 1921, by a recorded vote of 63 to 7. It was approved by the House on November 19, 1921, by a vote of 279 to 39. The bill became law on November 23, 1921, when President Harding signed the Sheppard-Towner Maternity and Infancy Act.

The Sheppard-Towner Act authorized an appropriation of $1,480,000 for fiscal year 1921-1922 and $1,240,000 each year for the next five years ending June 30,1927. Of this sum, $5,000 would go to each state if matching funds were provided; and the rest would be scattered on a population percentage and matching basis. The Children's Bureau had responsibility for administering funds through the state child welfare or health division. Both the state and the individual retained the right to reject the aid under the law. Before any grant could be made, the state agency was required to submit detailed plans to a Federal Board of Maternity and Infant Hygiene concerning the operation and expenditures of the state program. The Federal Board consisted of the Surgeon General of the Public Health Service, the Chief of the Children's Bureau, and the Commissioner of Education. This panel made periodic reports to the Infant Hygiene Division. State plans were required to include provision for instruction in the hygiene of maternity and infancy through public-health nursing and consultation centers, and also to provide for medical and nursing care for mothers and infants at home or at a hospital when necessary, especially in rural areas.

The response to the Sheppard-Towner Act was generally favorable. The majority of the states not only quickly accepted the federal
proposal but also authorized their matching appropriations. By June 30, 1923, 40 states had accepted the provisions of the Act. Of these states, complete matching state funds were approved in 17 states, partial ones in 18, and the $5,000 outright grant in only 6. By 1925, all states had accepted the Act except Massachusetts, Connecticut, and Illinois. State activities included an increase in the number of public-health nurses and physicians in rural areas; the establishment of maternal and infant health centers; stimulation of better birth registration; improvement in milk supplies, studies of the midwife problem, and health conferences held by specialists in maternity and child health; the distribution of supplies to mothers unable to go to hospitals for confinement; and general educational activities through literature, exhibits, lectures and demonstrations in addition to surveys of maternity homes and infant homes.

Public knowledge of the health problems of the infant and child was increased through 183,252 health conferences held between physicians, dentists, and nurses and expectant mothers and children; the 2,978 permanently established child-health, prenatal, and combined prenatal and child-health centers; the 19,723 classes held between 1927 and 1929 to instruct girls, mothers, and mid-wives; 3,131,996 visits by public health nurses to mothers from 1923 to 1932; and the 22,030,489 pieces of literature distributed by the participating states.

By 1929, the infant mortality rate had fallen to 67.6 per 1,000 live births, compared with 100.9 in 1918. During this same period, the maternal mortality rate per 10,000 live births decreased from 91.6 to 69.5. In 1922, the Children's Bureau created the Maternity and
Infant Act. This Division kept in touch with the work of the states through reports from the states, staff visits to the states, and annual conferences of directors of the state bureaus and divisions in charge of the administration of the act. In addition, the Maternity and Infant Hygiene Division assisted the states by arranging for nursing institutions or maternity and infant care. This was done through the loan of Bureau personnel for demonstrations and surveys, and by undertaking special studies related to the nutrition of children, the mental health of school children and maternal mortality.  

Although the Sheppard-Towner Act was accepted by a large majority of the states, a considerable amount of opposition developed. The Connecticut legislature refused to accept money on the ground that it infringed on the rights of the state. However, the state of Massachusetts spawned most of the organized effort against the Act. The state filed a suit with the U.S. Supreme Court on behalf of its taxpayers to enjoin the law. Fearing that the state was ineligible to file a taxpayers suit, Harriet Frothingham filed a similar suit in the courts of the District of Columbia. Both the Supreme Court of the District of Columbia and the Courts of Appeal of the District upheld the law and an appeal was taken to the U.S. Supreme Court. On June 25, 1923, the Supreme Court dismissed both suits "for want of jurisdiction," without considering the merits of the constitutional questions.

The Sheppard-Towner Act was considered a permanent law, but the appropriation was for a five-year period ending June 30, 1927. Confident that the program was a success, the proponents urged a renewal of its appropriation for a two-year period. The House of Representatives
quickly voted a two year extension by the margin of 218 to 44, but opponents mobilized to block the bill in the Senate. The foes included the American Medical Association, Woman Patriots, Massachusetts Public Interests League, Sentinels of the Republic, and the Daughters of the American Revolution.

A compromise was finally negotiated which extended the appropriations for two more years but repealed the law itself automatically on June 30, 1929. Supporters of the bill hoped that a more favorable political climate would exist by 1929 and that the law would be restored. Efforts to preserve the maternity program were resumed in 1928 by the Children's Bureau, Women's Joint Congressional Committee, and other concerned groups. However, by 1929 the political climate had shifted even further to the right. President Hoover refused to support renewal, allowing the first federal social security law to lapse on June 30, 1929.

The Sheppard-Towner Act of 1921 was a direct out-growth of the Bureau's early study of infant and maternal mortality. This short-lived program—it was in effect for only seven years—demonstrated the feasibility of providing local health services for mothers and infants, with the use of federal funds. The Act, furthermore, provided the Bureau with knowledge and experience useful later in laying the foundation for the maternal and child health program under the Social Security. Dr. Martha M. Eliot summarized the importance of the Sheppard-Towner Act when she stated, "The Sheppard-Towner Act established the national policy that the people of the United States, through their federal government, share with the states and localities the responsibility for
helping to provide the community services that children need for a good start in life. After the federal law lapsed most of the states continued maternity and infancy aid on their own. The removal of federal funds, however, greatly restricted the programs with only 16 states appropriating enough money to exceed or equal the previous total. States began to divert maternity and infancy appropriations to other health activities.

From 1929 to 1933, legislators introduced 11 bills to renew the Sheppard-Towner Act. These bills were named for the two Congressmen who introduced them--Republican Senator Wesley L. Jones of Washington, and Republican Representative John G. Cooper of Ohio. The first Jones-Cooper bill was different from the Sheppard-Towner law in only a few respects. Each state was to receive $15,000 of the $1,000,000 appropriation which it had to match fully. There was no time limitation on the bill as there had been on the Sheppard-Towner Act.

At the second session of the Seventy-first Congress, Cooper introduced a second bill for maternity and infancy aid, adding an entire new aspect: the development of local health services. Each state or territory was to receive $10,000 for infant and maternity welfare work subject to the recommendation of the chief of the Children's Bureau; in addition, $10,000 was appropriated for the development of local health services with the approval of the Surgeon General of the U.S. Public Health Service. Participating states were required to match both grants. The Children's Bureau opposed the bill because it posed a threat to its work. Action on the Jones and Cooper bills and other similar bills was basically non-existent during the remainder of
Hoover's term.

The Children's Bureau proceeded along other fronts to reduce infant mortality. In 1922, the Children's Bureau began a study in the District of Columbia on the growth of young children. The project workers studied the diets of young children with special reference to the diets of their mothers during pregnancy. This study was followed by a three years' demonstration of community control of rickets, conducted in New Haven, Connecticut, in conjunction with the pediatric department of the Yale University School of Medicine and the New Haven Department of Health. In order to assist in proper interpretation of data secured in the New Haven study, an investigation was conducted in Puerto Rico to secure a series of x-rays of bones of infants living in the tropics. Investigators assembled data on the growth and nutrition of the infants, the presence of physical defects, diets of the children and home conditions. The results of the studies indicated that simple measures could be employed to prevent rickets and related diseases. This research led to important conclusions concerning the efficiency of cod-liver oil, sunlight, vitamin E, and evaporated milk in preventing rickets.

In 1927-1928, during the last two years of the operation of the Sheppard-Towner Act, the Children's Bureau initiated a detailed case by case study of maternal mortality in 15 states. This study was conducted because there was no striking change in maternal death rates during the first five years of the program. The study was conducted with the advice of a nation-wide committee of obstetricians in cooperation with state departments of health. Results of the study showed a
high correlation between the kind of prenatal and medical care given
and the death or survival of the mother.

Following this pilot study, the New York Academy of Medicine
and Philadelphia Medical Society took up the study of Maternal Mortal-
ity, and the Obstetric Advisory Committee of the AMA adopted a set of
guidelines preparing the way for improvements in maternity care.

In the 1920's, the Children's Bureau began to receive inquiries
about the work being done for crippled children in the states. To
answer these questions, the Bureau undertook an extensive study of
public and private programs for crippled children in 14 states repre-
senting different sections of the country and both rural and densely
populated regions. The study included an examination of public pro-
visions for hospital and convalescent care, methods of locating crippled
children, and preventive measures. The findings were later the basis
of the Bureau's recommendations to the President's Committee for the
program for crippled children in the Social Security Act.

Crippled children's programs and maternity and infancy care
were the major topics of the White House Conference on Child Health and
Protection which met November 19 through 22, 1930. When the White
House Conference opened after 16 months of elaborate planning, some
3,000 delegates attended the session. Dr. Ray Lyman Wilbur, Hoover's
Secretary of the Interior, was general chairman of the Conference. In his opening speech, President Hoover devoted his attention primarily
to education in physical and mental health, aid to handicapped children
and the physically defective, the protection of the infant and mother,
and the problem of the delinquent child. He made one brief reference
to maternity and infancy aid: "We have grave responsibility to the rural child. Adequate expert service should be . . . available to all from maternity to maturity."61

During the Conference various committees recommended the renewal of the Sheppard-Towner Act. The Committee on Dependency and Neglect recommended the passage of a new maternity and infancy act.62 The Committee on the Federal Government and Child Welfare endorsed the use of federal grants-in-aid as a means of promoting child care. The Chairman of the Committee on Prenatal and Maternity Care urged an increase in the personnel and appropriations given to the Children's Bureau although the Committee as a whole did not adopt a resolution on the topic.63

The Committee on Public Health Service and Administration chaired by U.S. Surgeon General Hugh S. Cumming, recommended that the Children's Bureau maternity and infancy activities should be transferred to the U.S. Public Health Service.64 Grace Abbott immediately protested, arguing that the total needs of the child should be considered as a unit by one governmental agency and that she would choose the most effective method of promoting the health of children over effective organization for improving the general health of children.65 The representatives of the twelve national organizations of women at the meeting were upset with the attempt to undermine the effectiveness of the Bureau's work. They wanted a Conference vote on it, but the chairman of the Conference insisted that his orders were that there would be no vote on controversial topics, and no further action was taken on the matter.66
During the deliberations, the crippled child was considered for the first time as a national problem—a consummation for which the Children's Bureau had worked during the preceding 10 years. The committee which studied the problem of the handicapped child reported a ratio of three crippled children to every 1,000 of the total general population, estimating that there were 368,325 crippled persons under 21 years of age in the United States in 1930. The same committee stated that there were at least 65,000 visually handicapped children in the United States of whom 15,000 were blind and 50,000 partially seeing and 2,000,000 children with impaired hearing, of whom 17,000 were deaf.

Based on the findings, such as these, the Conference issued this set of recommended actions:

1. States should set up responsible departments to which crippled children should be reported.
2. The benefits of medical science should be made available to all.
3. Proper convalescent and follow-up services should be provided enlisting parental cooperation.
4. Every crippled child should be provided with an education at public expense, special emphasis to be placed on vocational training and placement.
5. Public funds should be provided to bring these things to reality.
6. The general public should be kept interested and enlightened as to the rights of the crippled and the importance of fitting the child into a normal life. The Federal Government should enact legislation and make appropriations in behalf of the physically handicapped.

The White House Conference crystallized the growing sentiment, throughout the United States for more adequate care of crippled children. The short comings of state-sponsored and administered legislation had become evident and the need for the National Government to
participate in the programs became apparent to the members of the Conference. Consequently, the report of the Conference recommended a nationally subsidized program to find physically handicapped children to provide expert diagnosis, adequate facilities for medical care and hospitalization, and to set up a federal program of research in behalf of crippled children.

Before the White House Conference adjourned, it approved a broad Children's Charter which urged:

For every child full preparation for his birth, his mother receiving prenatal, natal, and postnatal care; and the establishment of such protective measures as will make childbearing safe.70

Finally Regional meetings on child welfare were held as part of the concluding activities of the Conference.

The creation of the Children's Bureau in 1912 marked the entry of the federal government into the general field of child health care. In its first decade of operation the studies of the Children's Bureau awakened the public to the deplorable maternal and infant death rate. During this period the Children's Bureau worked in conjunction with the National Women's Organization during the Children's Year Campaign and the White House Conference of 1919 to increase the public's awareness of this critical issue. The work of the Children's Bureau together with that of the state health departments resulted in significant contributions for the betterment of children's health. Problems that were studied during this time included the reduction of infant mortality; birth registration; the promotion of maternal, prenatal, and infant care; and the prevention of illness at home. Crippled children also received attention which had been unknown previously. All of this led
to the demand for a federally directed effort for the protection of mothers and children and the passage of the Sheppard-Towner Maternity and Infancy Act in 1921. The controversial Sheppard-Towner Act, administered by the Children's Bureau, stimulated the development of maternity and child health programs in all the states and laid the groundwork for Title V of the Social Security Act of 1935.
NOTES

1R. G. Freeman, "Pasteurized Milk as Supplied to the Poor by the Straus Milk Depot of New York," Medical Record, XLVI (1894), 133-134. The benefits obtained from the Straus "Milk Depots" is clearly shown by the trend of the infant mortality rate in New York City. In 1885 the infant death rate was 273 per 1,000 live births; by 1915 it had dropped sharply to 94 per 1,000.


4Ibid., p. 366.

5Ibid.


13Ibid., p. 100.

17 U.S. Statutes at Large, XXXVII, Pt. 1, pp. 79-80.
22 Abbott, Ten Years, pp. 3-4.
24 Ibid., pp. 8-9.
26 Ibid.
27 Federal aid to crippled civilians was included in the Smith-Bankhead bill, but this provision of the Act failed to get congressional approval.
32 Ibid., p. 49.
33Ibid., pp. 48-50; Seventh Annual Report (Washington, D.C., 1919), p. 25; Robert D. Leigh, Federal Health Administration in the United States (New York, 1927), p. 412. By the Smith-Lever Act, federal money was appropriated for rural home demonstrations in agriculture and home economics, provided that the cooperating states matched the federal funds equally.

34Even after the passage of the Sheppard-Towner Act, the AMA was relatively mild in its opposition. For a summary of the Sheppard-Towner Act published by the AMA see A. E. Rude, "The Sheppard-Towner Act in Relation to Public Health," Journal of the American Medical Association, LXXVIII (1922), 959.


37Ibid., p. 183.

38Congressional Record, 67 Cong., 1 Sess. (1921), LXI, Pt. 4, p. 4217; ibid., Pt. 8, pp. 8036-8037.

39Ibid., pp. 8115, 8154, 8178.

40U.S. Statutes at Large, XXXXII, Pt. 1.

41U.S. Children's Bureau, The Promotion of the Welfare and Hygiene of Maternity and Infancy, Pub. No. 48 (Washington, D.C., 1924), pp. 3-5. The first six states to accept were Mississippi, New Jersey, South Carolina, Virginia, Kentucky, and Maryland.


44Ibid., pp. 4-6.


46Congressional Record, 71 Cong., 3 Sess. (1930), LXXIV, Pt. 1, p. 422.

48 U.S. Department of Labor, Report of the Secretary of Labor and Reports of the Bureaus, 1923 (Washington, D.C., 1924), pp. 117-120. By the decision, the Supreme Court allowed not only the Sheppard-Towner Act, but all other similar acts of Congress, to stand and function. The two courts' decision established the legal groundwork for Title V of the Social Security Act.

49 Congressional Record, 69 Cong., 2 Sess. (1926), LXVIII, Pt. 6, pp. 6918-6920, 6926. The Senate introduced an amendment to the House bill to terminate the legislation on June 30, 1929. There was no recorded vote in the Senate on the renewal bill.


53 Congressional Record, 71 Cong., 1 Sess. (1929), LXXI, Pt. 1, pp. 106, 151. The Senate bill was S. 255 and the House bill H.R. 1195.

54 Congressional Record, 71 Cong., 2 Sess. (1930), LXXII, Pt. 4, p. 3706.


60 Chambers, Seedtime of Reform, p. 56.

61 White House Conference, Proceedings, p. 3.

62 Ibid., pp. 46-47.

63 Ibid., pp. 9, 48.
64 Ibid., pp. 33-34.


70 Ibid., p. 3.
CHAPTER II

ORIGINS OF THE CHILD HEALTH TITLE OF THE
SOCIAL SECURITY ACT

A variety of forces led to the enactment of the child health provisions of the Social Security Act. Some of these forces had been gradually developing since the early 1900's and represented the culmination of federal, state, and local efforts to make better provisions for protection and promotion of the well-being of children.

Directly related to Title V, Grants to States for Maternal and Child Welfare, of the Social Security Act was the desire of the Children's Bureau to continue the work of the Sheppard-Towner Act, especially during the Depression. The continuing high infancy and maternity death rate in the United States combined with evidence that the Depression had resulted in a retrogression in health services to children contributed to the inclusion of Title V in the Social Security bill. The forces were closely interrelated and often not sharply distinguished from one another.

The Depression brought a drastic reduction in state and local maternal and child health services. The shrinkage of the tax base of many local governments necessitated the curtailment of some government activities. The tendency was to cut off the newer services first because they were less firmly established by law and in the community.

26
public opinion. This was corroborated by a study of the National League of Women Voters in 1931.\(^1\) Even as early as June 29, 1929, the expiration date of the Sheppard-Towner Act, states began to divert maternity and infancy appropriations to other health activities. In some jurisdictions this occurred because emergencies arose in other fields or because there was the temptation to give the money to projects that produced speedier results. Of the states that cooperated with the Sheppard-Towner Act, 21 states appropriated more in 1930 than they had in 1929, and another 23 states appropriated the same amount or less in 1930 than they had in 1929.\(^2\) However, by 1934, after four years of depression, 37 state legislatures had decreased or eliminated appropriations for child health care, while only eight states appropriated $25,000 or more to carry on this vital work. Fourteen states had no funds at all or less than $3,000.\(^3\)

The reduction in funds or their complete elimination seriously handicapped the maternal and child health work in most states. These reductions meant a cut back in the number of public health nurses, the elimination of many prenatal and child health conferences, and serious curtailment of educational work with parents and students. These funding cuts occurred at the very time when increased need among families of the unemployed called for more, not less, maternal and infant care.

The effect of the Depression on child health soon became clear. In a speech before the American Academy of Political and Social Science in Philadelphia in 1930, Grace Abbott, Chief of the Children's Bureau, stated that food and milk were in short supply and private medical care was in shorter supply.\(^4\) As a result children would suffer for years to
come from the deprivation caused by curtailed appropriations. Others attested to the plight of mothers and infants. For example Senator Royal Copeland, former President of the New York Board of Health, was worried about undernourishment and malnutrition, which would affect the mortality rates of pregnant women and newborn babies.\

During the summer and fall of 1933, three investigations verified to a great degree previous impressions of widespread illness and malnutrition among infants and children. Early in June, 1933, a report entitled "Idleness and the Health of a Neighborhood" was issued by the Association for Improving the Condition of the Poor in New York City. The report was based on two surveys of the Mulberry Health Center District, one in November, 1932, and one in April, 1933. An 84 percent increase in illness in the total group was reported to have occurred between November and April. The children showed an even more striking increase in the number of illnesses than did the group as a whole. Out of every 1,000 children under six years of age visited, 260 were ill at the time of the second survey in 1932, whereas in 1930 only 91 were reported ill—an increase of 185 percent. In its summary, the report stated, "Child health has undoubtedly suffered in Mulberry during the Depression."

In October, 1933, the first of a series of reports was issued by Drs. G. J. Perrott, S. D. Collins, and E. Sydenstricker dealing with a comprehensive investigation of "Sickness and the Depression" in 10 localities including the poorer districts in eight cities, a group of coal mining communities, and five cotton mill villages. Results of their survey showed a higher incidence of disabling illness in 1932 and
1933 among individuals in the lower income classes than among individuals with higher incomes. The illness rate was reported to be 60 percent higher among members of families whose income had dropped from "comfortable" circumstances in 1929 to "poor" by 1932. The report further stated "the rate of disabling illness reported among individuals from families of the unemployed was 39 percent higher than that of the group containing part-time but no full time workers." The report showed that the total sickness rate for children was much higher for those of the "depression poor" than for children of the families who had not suffered a decreased income. Furthermore, the children under 15 years of age among the "depression poor" showed a much higher rate for respiratory diseases than did children of the same age in families who remained in "comfortable" circumstances. The reports showed, as might be expected, that children of families of the "depression poor" received less care from physicians than did the children of the more wealthy families.

As part of the investigation, Drs. Kiser and Stix examined 1,000 children from families in poor areas of New York City and Pittsburgh in order to study the relation of malnutrition to economic status. According to the Kiser and Stix report, more than 40 percent of the children from families in the lowest income group at the time of the investigation in 1933 were classified as having "poor" and "very poor" nutrition, in contrast to only 24 percent of the children from families in the highest income group. The investigators pointed out:

... the proportion of children suffering from malnutrition in the group examined appears to be considerably larger than the proportion of malnourished children we should expect to find in a
nondepression era. While we have no records for other groups of children which are directly comparable with our data, the difference in the prevalence of malnutrition among children of lower income families, in which there has been relatively little change in income since 1929, is definitely shown for the group included in this study.14

Palmer made a third investigation on the effect of the Depression on child health and development.15 The survey was undertaken with the purpose of determining whether or not the weights of elementary school children in Hagerstown, Maryland, differed in 1933 from the weights of children of the same age and sex during a 10 year period.16 Comparison was made of the weights of school children in May, 1933, with those of school children weighed in May, 1921, through 1927. Palmer found a significantly higher proportion of children who were underweight in 1933 than had been underweight in the 1921-1927 period.17

The Committee on the Costs of Medical Care (which was organized in the fall of 1927, following a conference in Washington of physicians, public health officers, and economists) reconfirmed the findings of the Children's Bureau. The Committee's final report, issued in 1932, revealed that millions of children in low income families lacked reasonably adequate medical care even in a time of general prosperity and that children, in general, suffered disproportionately to their numbers.18

On the basis of findings such as these, the Committee on the Costs of Medical Care issued a set of recommendations: increased federal grants-in-aid to provide needed medical services in the rural areas of the country; the strengthening and extension of the public health service; coordinate, evaluate, and supplement community medical
services; and increased governmental responsibility for the medical care of the children, veterans, and for the treatment of certain classes of diseases. The majority of the members of the committee endorsed the idea of voluntary health insurance, but they recommended that the cost of health insurance could come from either or both private and governmental sources.

Early in 1933, the state of Pennsylvania initiated the first comprehensive program to meet the emergency in child health care. Governor Gifford Pinchot, former Chief Forester of the United States, called together a large number of individuals interested in child welfare for a conference on malnutrition. The Pennsylvania Medical Society cooperated with the conference on a plan to conduct a series of physical examinations of children in families on relief. By February 1, 1934, 46 country Emergency Child Health Committees were organized and more than 30,000 children had been examined by physicians. In the follow-up program the county committees took immediate steps to insure better diets for undernourished children, to arrange for dental care, for immunization and for tonsillectomies. In addition other special efforts were made to reach all pregnant women on relief rolls and to arrange for prenatal examinations. The physical examinations revealed that many children suffered from malnutrition.

On October 6, 1933, Frances Perkins, The U.S. Secretary of Labor, requested the convening of a Child Health Recovery Conference to be held under the auspices of the U.S. Children's Bureau for the purpose of stimulating public interest in the health of children who had suffered as a result of the Depression. An executive committee
did the organizing for the Conference with a three-point program: (1) Location of undernourished children; (2) Physical examination of all children in families on relief; (3) Public protection of maternity and infancy.

When the Child Health Recovery Conference opened after two months of elaborate planning, some 150 health officers, directors of child hygiene departments, physicians interested in child health, and social workers attended the session. The chairman of the Child Health Recovery Conference, Dr. Martha M. Eliot, presented to the delegates evidence of malnutrition among school children that had been collected by the Children's Bureau over a three year period. Harry Hopkins, Federal Relief Administrator, in a letter to the Conference stated that six million children were on public relief in the United States. Dr. Samuel M. Hamill, a member of the Philadelphia Academy of Pediatrics, in his address to the Conference, described in detail the state-wide Pennsylvania child health program. The Conference then proposed a nation-wide program to locate and help malnourished children. Furthermore the Children's Bureau was asked to stimulate communities and states to undertake the examination of children from families on relief. There was also an emphasis on helping the children of families who though not yet on relief were nevertheless in need.

To assist the states in the preparation of programs for increased child health activities, the Children's Bureau made available three of its staff physicians for consultation work. The Bureau later added Dr. Juanita M. Jennings from the State Bureau of Maternal and Child Health in Kentucky, and Dr. Edith B. Sappington from the State
The American Child Health Association lent the service of its medical director, Dr. Clara Hayes, for three months. In a majority of the states, the child hygiene divisions of the state health departments, in association with local pediatric societies, led the way in organizing campaigns to help underprivileged children. In some states, the organization that was established following the 1930 White House Conference on Child Health and Protection assumed responsibilities in connection with the program. Where no state-wide organization existed, local groups organized working committees in various counties to undertake important pieces of child health care work. In their effort to implement suggestions of the Child Health Conference, the state committees made child care a matter for relief. Four states supplied extensive prenatal and postnatal care, especially among women in families on relief.

The Federal Emergency Relief Administration authorized the use of federal funds for hot school lunches for undernourished children from families on relief and for the correction of medical defects interfering with nutrition of children. In December, 1934, the Federal Civil Works Administration proposed that a plan to be worked out by the Children's Bureau and by state health departments for child health nursing services as a Civil Works Administration project. State health departments submitted an estimate of the number of nurses and supervisors that could be used to advantage in the child health field; 30 states and Puerto Rico finally participated in the program. The Civil Works Administration estimated that a minimum of 2,000
nurses, including approximately 200 qualified public health nurses as supervisors, participated in the program. One million preschool and school children were examined by nurses and where possible, given free medical care.  

By the fall of 1934, there was ample evidence of the need for renewal of grants to states for maternal and child-health programs, and for the establishment of federal aid for the medical, hospital, and follow-up care of crippled children. Reports prepared for the President's Committee on Economic Security in the fall of 1934 showed that nine states no longer authorized state funds for child health services. Twenty-eight states had decreased their appropriations and only five made appropriations equal to or above their combined federal-state funds. It took the calamity of the Depression, and in 1934, an increase in the national infant mortality rate to demonstrate that the former federal-state cooperation in the provision of health services to children and mothers was essential.

Based on the data collected during the first three years of the Depression, the Children's Bureau prepared a "suggested plan for children's health and welfare programs." The plan, which was to become the basis for the child health and welfare section of the Social Security Act, comprised three major program proposals: (1) aid to dependent children; (2) maternal and child welfare services, including services for crippled children; and (3) child welfare services for children needing special care. In the first part of the plan was a requirement that state plans for aid to dependent children must furnish "assistance at least great enough to provide, when added to the income
of the family, a reasonable subsistence compatible with decency and health."

The second part of the Children's Bureau plan was for a maternal and child health program broader than the Sheppard-Towner Act, and with a doubling of the appropriation. A provision allowing for an appropriation directly to the Children's Bureau was to be used in collaboration with the states for "demonstrations." Congress converted this into the "B" Fund, which served as a foundation for innovative "project grants."

An entirely new development was the proposed programs of federal grants to states for crippled children's services. There was sufficient evidence to conclude that thousands of children would go through life with severe handicaps if more public funds were not made available for services to crippled children. The grants were not intended simply to pay medical bills, but were to enable states to organize new and better programs of care, and, as the Act stated, "to extend and improve . . . services . . . for crippled children." The program proposed that the states offer an entire array of services, beginning with the finding of crippled children and including the medical, surgical, and other needed services and after care. The proposal established the concept that this new medical care program would also include preventive services as well as needed medical and surgical treatment.

The third proposal was for grants to enable states to establish, extend, and strengthen child welfare services for children needing special care.
Thus, by 1934, the country was ready for a new and more comprehensive program of health services for children. In a message to Congress on June 8, 1934, the President proposed a program of reconstruction from the Depression which included a maternal and child health program. In his message he stated:

Among our objectives I place the security of the men, women, and children of the Nation first. This security for the individual and for the family concerns itself primarily with three factors. People want decent homes to live in; they want to locate them where they can engage in productive work, and they want some safeguard against misfortune which cannot be wholly eliminated in this man-made world of ours.38

The President reviewed completed and uncompleted legislation related to economic security and announced that it was his intention to appoint an executive committee to develop a wide program of economic security which he would then present to the next session of Congress.39

On June 29, 1934, by executive order, the President created the Committee on Economic Security, which was to "study problems related to economic security of individuals," and report to the President its recommendations for proposals to "promote greater economic security."40 A second agency, the Advisory Council on Economic Security, was established to "assist the committee in the consideration of all matters coming within the scope of its investigations."41 A third agency, a Technical Board consisting of "qualified representatives to be selected from the various departments and agencies of the federal government," was to be appointed by the Committee on Economic Security. Provision was made for an executive director, to be appointed by the Committee on Economic Security. He was to have:

... immediate charge of studies and investigations to be
carried out under the general director of the Technical Board, and who shall, with the approval of the Technical Board, appoint such additional staff as may be necessary to carry out the provisions of the order.42

At the first formal meeting of the Technical Board, on August 10, 1934, it was decided that the Board should function through an Executive Committee and five special committees: unemployment, insurance, old age security, public employment and relief, and medical care.43 The Committee on Medical Care argued the pros and cons of including health insurance provisions in the bill. When the bill was introduced, health insurance was not included but the discussion opened the way for consideration of grants-in-aid to the states for general public health, maternal and child health, and medical care of crippled children. Miss Katharine Lenroot, the new Chief of the Children's Bureau, and Dr. Martha M. Eliot of the staff of the Bureau, who had been appointed to undertake a study of the problem of security for mothers and children, seized the opportunity to support the new health proposals.44 In the course of deliberations, public health advisors and staff requested that funds for the children's health services be combined with those for general public health and administered by the Public Health Service while the Children's Bureau provided technical advice. The impracticality of such a suggestion led to its withdrawal.

With little formal debate, the Committee on Medical Care recommended that federal subsidies should be given for health aid to mothers, children, and cripples.45 This recommendation was formally adopted by the Technical Board and presented to the Committee on Economic Security at the meeting on October 1, 1934.46
The executive order which created the Committee on Economic Security also provided for an Advisory Council, to be composed of individuals outside of the government whose function it would be to advise the Committee on the legislation to be recommended. The Advisory Council numbered 23 members, including Grace Abbott of the University of Chicago, former Chief of the U.S. Children's Bureau. The Advisory Council held its first formal meeting on November 15. Following an address by Secretary Perkins, the council proceeded to a discussion of an extended memorandum which Professor Witte had prepared to serve as a basis for the initial discussion. In the memorandum, the Executive Director outlined a program covering 10 major subjects: unemployment insurance, employment assurance, relief, old age security, medical care for low-income groups, security for children, workmen's compensation, non-industrial accidents, survivors' insurance, and invalidity insurance.

In the field of child health, the Advisory Committee readily accepted the recommendations of the Technical Committee. The final report of the Advisory Council, prepared by William Green, Paul Kellogg, and Grace Abbott, consisted of five parts: unemployment compensation, old age security, security for children, employment and relief, public health and medical care. Part II of the report dealt with "Security for Children." After pointing out that "certain special measures are necessary for the protection of children," the report proposed a child and maternal health program involving federal assistance to the states, and through the states, to local communities, in the extension of maternal and child health services, particularly in rural areas.
Starting on October 11, 1934, the Committee on Economic Security held a series of meetings to discuss the recommendations of the Technical Committee and the Advisory Council. At its meeting on December 4, the Committee on Economic Security considered the proposals relating to public health and child welfare. A majority of the members favored federal grants-in-aid on the basis of one-half the state and local expenditures for child health and welfare.52

At an informal meeting on the night of the 19th in the home of Secretary Perkins, agreement was reached on all major recommendations, including maternal and child health care. On December 24, Secretary Perkins and Administrator Hopkins went to President Roosevelt and presented their recommendations.53

A final draft of the report was sent to the President on January 15, 1935. Its major recommendations covered employment assurance, unemployment compensation, old age security, security for children, risk arising out of ill health, and residual relief. In a summary of the major recommendations, the report stated:

We recommend also that the Federal Government give assistance to States in providing services for the protection and care of homeless, neglected, and delinquent children and for children and maternal health services especially in rural areas. Special aid should be given toward meeting part of the expenditure for transportation, hospitalization, and convalescence care of crippled and handicapped children, in order that those very necessary services may be extended for a large group of children whose handicaps are physical.54

The report summarized some of the evidence brought out during the hearings with respect to the needs of children as follows:

The fact that the maternal mortality rate in the country is much higher than that of nearly all other progressive countries suggests the great need for federal participation in a nationwide
maternal and child health program. From 1922 to 1929 all but three states participated in the successful operation of such a program. Federal funds were then withdrawn and as a consequence state appropriations were materially reduced. Twenty-three states now either have no special funds for maternal and child health, or appropriations for this purpose are $10,000 or less. In the meantime, the need has become increasingly acute.

Crippled children and those suffering from chronic diseases such as heart disease and tuberculosis constitute a regiment of whose needs the country became acutely conscious only after the now abandoned child and maternal health program was inaugurated. In more than half of the states some state and local funds are now being devoted to the care of crippled children. This care includes diagnostic clinics, hospitalization and convalescent treatment. But in nearly half the states nothing at all is now being done for these children and in many the appropriations are so small as to take care of a negligible number of cases. Since hundreds of thousands of children need this care the situation is not only tragic but dangerous.

Later in the report, in discussing the amount to be appropriated for maternal and child health services, the Commission urged:

But we cannot too strongly recommend that the federal government again recognize its obligation to participate in a nationwide program saving the children from the forces of attrition and decay which the depression turned upon them above all others.

In a special message on January 7, 1935, when the President transmitted the report of the Committee on Economic Security, he recommended that legislative action be taken to realize the objectives sought in the report. In the message he urged that a definite program "should be brought forward with a minimum delay."

The President then recommended the following specific types of legislation looking forward to economic security:

(1) Unemployment insurance
(2) Old Age Benefits, including compulsory and voluntary annuities
(3) Federal aid to dependent children through grants to the states for the support of existing mother's pension systems and services for the protection and care of homeless, neglected, dependent, and crippled children.
(4) Additional federal aid to state and local public health
On January 17, 1935, Representatives Doughton and Lewis each introduced into the House a bill carrying out the recommendations of the Committee on Economic Security. On the same day, Senator Wagner introduced a bill in the Senate which was identical in content with the bills introduced separately by Representatives Doughton and Lewis. The Wagner Bill (S. 1130) was referred to the Senate Finance Committee, while the Doughton Bill (H. R. 4120) and the Lewis Bill (H. R. 4142) were referred to the House Ways and Means Committee.

The two types of grants eventually included in Title V of the Social Security Act were contained under Title VII of these bills. Minor changes were made in the details within the provisions for each of these two types of grants by the House Ways and Means Committee with additional changes being made by the Senate Finance Committee. Ultimately the Administration bills were the same as the bills considered in the Congress. Specifically, the general purposes for which grants were authorized were the same in all versions.

The original bill made appropriations for welfare and health purposes. A sum of $4,000,000 was to be provided, on an annual basis for the purpose of maternal and infant care, "especially in rural areas and in areas suffering from severe economic distress." Unless deterred by "exceptional circumstances," the states were expected to match the amount of the federal grant.

To provide services for crippled children, a yearly sum of $3,000,000 was to be authorized through the law and, except in situations of severe economic distress, the federal grants were to be
matched on an equal basis by the states. An additional sum of $1,500,000 a year was to be authorized for various child welfare purposes. The major portion of this, as in the other welfare grants, was to be matched by corresponding state appropriations, but some was to be given outright to the financially depleted states.

Within a week after the introduction of the Administration bills, the House Ways and Means Committee and the Senate Finance Committee each began hearings on the proposed legislation. These hearings continued until February 12, 1935, before the House Committee, and until the twentieth of that month before the Senate Committee.

A number of prominent witnesses appeared before the House Ways and Means Committee in support of the Title VII grants. Practically no opposition was expressed in the hearing with respect to the two grant programs proposed. Testimony was in the nature of presentation of evidence as to the need for these subsidies to the states. There was of course an occasional suggestion for modification or clarification of a particular provision of the bill. For example, Miss Lenroot, the new Chief of the Children's Bureau, testified that the maternal mortality rate was still seriously high compared with other countries although the infant mortality rate, comparatively speaking, was not "bad." In her testimony she made reference to the very limited provisions for crippled children and the importance of federal aid for the expansion of such work.

At this point, the House Ways and Means Committee considered whether assignment of the child health grant-in-aid programs should be to the Public Health Service (as the American Medical Association
preferred), or to the Children's Bureau. The Committee decided that the program should be administered by the Children's Bureau, having heard Miss Lenroot's testimony on the relation of child health and child welfare services. Furthermore, the Public Health Service showed no enthusiasm for entering into the provision of medical care. The Committee took into consideration the past record of the Children's Bureau administration of the Sheppard-Towner Act.

In Miss Lenroot's testimony before the Ways and Means Committee, she made the following statement with respect to the amounts of money authorized for children's services:

The amount of money included in the bill are very conservative, as I shall point out in discussion of the specific sections. We might well have justified larger amounts, but we felt that in undertaking programs of this kind there were certain administrative developments that had to be made, there were questions of availabilities of personnel that had to be settled, and since this is not an emergency measure, but a measure of permanent cooperation, it was felt that it was better to begin on a modest basis with a program that we thought could be immediately put into effect.67

The Ways and Means Committee concluded its consideration of the economic security program by producing a revised bill.68 While this bill did not differ greatly from the original in content, it did look entirely different in its order of titles. In this new bill Title V included the two Maternal and Child Health Grant programs under Social Security. The bill was given a new number—H. R. 7260 and also a new general title. Up until that time, it had been called the "Economic Security Bill;" now it became known as the "Social Security Bill."

On April 5, 1935, a favorable report recommending passage of H. R. 7260 was filed by the Ways and Means Committee.69 The first part of this report, written by Professor Witte and Dr. Harris, consisted of
an argument for the passage of the bill. The second part, written largely by John Beamai and Thomas Eliot was a detailed explanation of the various provisions of the bill.70

In Title V it is proposed that aid be given the states for other services very essential to the security of children. The first of these is aid for maternal and infant welfare, particularly in rural areas and in areas suffering from severe economic distress.

Federal aid is also given for hospital care of crippled children. In proportion to the great need which exists, however, the provisions for crippled children are very limited. To stimulate an expansion of such work the bill gives Federal aid to the states for this purpose.71

The minority members of the Committee submitted a statement of "minority views" which was included as part of the Committee report. The following abstract contains what was said in that statement concerning Title V:

The bill is separated into several titles, which readily and naturally separate themselves in two categories:

(1) Those which spring from the desire of the Federal government to provide economic assistance to those who need and deserve it.

(2) Those which are based upon the principle of compulsory insurance.

In the first group are:

Title I, granting aid to the states meeting the cost of old age pensions.

Title IV, granting aid to the states in caring for dependent children.

Title V, granting aid to the states in providing for maternal and child welfare.

Title VI, granting aid to the states in providing for public health generally.

We favor the enactment of each of the foregoing titles, which in our opinion should have been incorporated in a separate bill. Title V. Maternal and Child Welfare. For years our Government has extended aid to the states, to provide for maternal and child welfare. Title V continues this aid in an increased amount.

We may add that we would favor a stronger and more vigorous program than that provided in this proposed legislation for the benefit of those covered by these three titles i.e., Titles IV, V, VI).72
Consideration of the Social Security bill on the floor of the House of Representatives began on April 11, 1935, and lasted until April 19, 1935.73 A total of 23 hours of general discussion was given to the measure, and about 50 amendments were offered.74 The debate and the controversy were focused on the provisions relating to old age assistance, survivors' insurance, unemployment compensation, and taxes on employment and employers (i.e., Titles I, II, III, VIII, and IX). There was only one reference to Title V. Members of the minority reiterated the position taken by minority members of the House Ways and Means Committee in support of Title V and certain other titles. A number of amendments to Title V were proposed, discussed very briefly, and rejected.75 The Social Security bill passed the House on April 19 by an overwhelming vote of 372 to 35. The bill as passed was in substantially the same form as it had been reported out by the Ways and Means Committee.76

When the House passed the Social Security bill, the Senate Finance Committee was preoccupied with other measures. It was unable to consider the revised Social Security bill until early May, approximately two and a half months after the completion of its hearings on the original bill.77 The Finance Committee went over the features of the revised House bill in detail, and reported the measure out favorably on May 13, 1935.78 The Finance Committee's report was prepared in much the same manner as was the report of the Ways and Means Committee. The first part was an argument for the bill representing a revision of the material which was contained in the House report. The second part followed the corresponding part of the report of the House Committee on
Ways and Means, with the necessary changes. No minority report was drafted.

In discussing provisions of the bill for "Security for Children," the Senate report commented:

The heart of any progress for Social Security must be the child. All parts of the Social Security are in a very real sense measures for the security of children.

Another provision in the same title gives federal aid to the states for the hospital and after care of crippled children. About one child in every 100 is crippled and only a small percentage of the crippled children have thus far received timely treatment.

In Title V the Federal Government undertakes to do its part for these children. The aid is required to be matched and it is hoped will stimulate many states which are not now doing anything for the crippled child to do work in this field.

Another aid provided for in Title V is for maternal and infant welfare. What is contemplated is not merely the same type of service which was given through federal aid from 1922 to 1929, but a program stressing particularly the rural areas and the smaller communities. It is not contemplated that the federal government shall directly engage in any of this work but that it shall give aid to the state for this purpose, particularly to develop adequate local services, in cooperation with existing agencies.79

In reporting on the provisions of the bill that related to crippled children the Senate Finance Committee said:

Early treatment in many of these cases can restore these children to an almost normal physical condition, while the failure to provide such treatment will result not only in lifelong physical impairment but often in public dependency.80

The Committee report contained estimates of crippling as high as 10 for every 1,000 persons under 21 years of age in the United States.81

On June 14, 1935, the entire Senate began consideration of the Social Security bill, which continued until June 19. The defense of the bill was handled by Senators Alben W. Barkley of Kentucky, Edward P. Costigan of Colorado, Pat Harrison of Mississippi, Robert M. LaFollette, Jr., of Wisconsin, and Robert F. Wagner of New York. There was
no debate on the floor concerning the Title V provisions and these were passed as recommended by the Senate Finance Committee. On June 19, 1935, the Senate approved the Social Security bill by a decisive vote of 77 to 6.82

The Senate amendments were rejected as a matter of course when they were brought up in the House. On June 29, the bill was sent to the bicameral Committee on Conferences and on July 17, the Conference Committee report was submitted to both Houses of Congress. The Conference Committee reached agreement on all but five of more than 100 amendments, the exception relating to Title VI and Title VII. Both Houses accepted the report of the committee but asked the Conference Committee to study the five unresolved amendments and report to the Congress. The House accepted the Conference Committee's second report83 on August 8, 1935, and the Senate on the following day84 in both cases without even a roll call vote.

Then, on August 14, 1935, in the presence of Secretary Perkins, Senators Barkley, Harrison, King, LaFollette, and Wagner, Representatives Doughton, Hill, and Lewis, and members of the White House Staff, President Roosevelt signed the measure into law, thereby making it the "Social Security Act."85

As finally enacted, part one of Title V of the Social Security Act, Maternal and Child Health Services, authorized federal appropriations "for the purpose of enabling each state to expand and improve, as far as practicable under the condition in such states, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic depression."86 The
emphasis was on the rural districts. Total annual appropriations of $3,800,000 were authorized, with the sum of $2,820,000 (Fund A) to be allotted on the basis of $20,000 to each state and a share of the remaining $1,800,000 to be appropriated on the basis of live births in the United States. To secure Fund A, the states would be required to contribute an equal sum. An additional sum of $980,000 (Fund B) was to be available on the basis of financial need of each state in promoting maternal and child health after the number of live births had been taken into consideration; matching with state or local funds was not required for Fund B.  

Part two of Title V authorized federal grants for the "purpose of enabling each state to extend and improve (especially in rural areas and areas suffering from severe economic distress), as far as practicable under the conditions of each state, services for locating crippled children and for providing medical services, surgical, corrective and other services and care, and facilities for diagnosis, hospitalization, and after care for children who are crippled or who are suffering from conditions which lead to crippling." Each state was to receive a uniform appropriation of $20,000. An additional $1,830,000 would be apportioned on the basis of the number of crippled children in each state and the cost of furnishing services to them. To secure these funds, the states would be required to contribute an equal sum.  

State plans had to be submitted to the Children's Bureau for approval before payment could be made to the states. State plans for maternal and child health services and services for crippled children had to show financial participation by the state itself, that is, use
of state funds as distinguished from funds made available by local political subdivisions. The state agency charged with these services was responsible for giving a full account of the administration of the act to the Secretary of Labor. The state agency also had to provide for cooperation with medical, nursing, and welfare groups and organizations, and in the case of the crippled children's service "with any agency in such state charged with administering state laws of physically handicapped children." State plans submitted had to include provisions for instruction in the hygiene of maternity and infancy through public health nursing and consultation centers and also provisions for the medical and nursing care for mothers and infants at home, or at a hospital when necessary.

In addition, the act required that in the maternal and child health plan there had to be provisions for the development of demonstration services in areas suffering from severe economic distress and among groups in special need. Hospitalization, surgery and after care were to be provided for children who were crippled or suffering from conditions that lead to crippling" and the state services were to be available to all state residents. The Chief of the Children's Bureau was to be the chief administrator, and was to conduct reviews of the funds allotted to the states.

The major forces underlying the enactment of Title V provisions of the Social Security Act may be summarized as follows: (1) the recognition, that had grown over a period of several decades and was reflected in earlier federal legislation, of the responsibility of the
federal government in the promotion and protection of the well-being of children; (2) the evidence that far greater needs for services for children had existed even in normal times than had generally been realized and that the curtailment of existing services as a result of the depression had brought about suffering among children and had endangered their well-being in many parts of the country; (3) the underlying conception of the federal program for recovery from the Depression that it should provide preventive measures to promote the security of adults and children as well as alleviative measures aimed at providing adequate income for families, and (4) the widespread conviction that special measures for the protection of children were a necessary part of a program aimed at economic security.

Title V of the Social Security Act provided for expansion and improvement of maternal and child health services, for special demonstrations projects of new types of services, and for meeting the needs of crippled children. Unlike the Sheppard-Towner Act, no time limit was set by the Act; the state health agencies were free to develop programs gradually and with a sense of permanence. The sponsors of Title V realized that many years of planning and program activity would be required to bring about a significant redirection in infant and maternal mortality. By omitting any time limit, Congress adopted the view that the federal government had a continuing responsibility to use its financial resources to improve the health of mothers and children. The language of the Act made it clear that the Children's Bureau would set the conditions for approval of state plans and establish basic policy related to content, scope and administration of the state
programs. The federal funds authorized for maternal and child health were approximately three times as great as those available under the Sheppard-Towner Act.

Furthermore, the Social Security Act proposed an entirely new medical care program for children. For the first time, federal grants were made available to organize programs of care for crippled children, including medical, surgical, and corrective services and care and facilities for diagnosis, hospitalization and after care. The law required the state's program to include the entire array of these medical services; no partial programs were to be approved. The way was open for broad state programs, since the Act put no limit on the types of crippled conditions a state could include in its program.93

Miss Lenroot noted the Social Security Act incorporated special measures for the protection of children as an integral part of a broad economic and social program.94 By establishing a system of unemployment compensation, it made possible a beginning, on a permanent and not an emergency basis, in collective provisions against one of the major threats to family life. The provisions relating to public health assisted in the development of a constructive program for improvement of community living conditions, sanitation, and protection of general health; at the same time it provided an opportunity for coordinated action in the field of public health, child health, and social service for children. The Social Security Act provided aid to the blind and federal aid for vocational-rehabilitation work, types of services which were of indirect benefit to children.
NOTES

1National League of Women Voters, The Nation's Concern for the Health of Mothers and Babies (Washington, D.C., 1931).


3"The Depression and Health Appropriations," The American Journal of Public Health, XXIII (1933), 1290.

4Congressional Record, 71 Cong., 3 Sess. (1930), LXXIV, Pt. 1, p. 946.

5Ibid., p. 938.

6G. H. Berry, Idleness and the Health of a Neighborhood (New York, 1933), p. 4.

7Ibid.


9Perrott, "Depression Poor," 101.

10Sydenstricker, "Sickness and the Poor," 160.

11Perrott, "Medical Care," 99.


13Ibid., 289-300.

14Ibid., 299.

Ibid., 1345.  

Ibid., 1342.  

Committee on the Cost of Medical Care, Medical Costs for the American People: The Final Report (Chicago, 1932), pp. 2-34. The Committee on the Costs of Medical Care was organized under the chairmanship of Dr. Ray Lyman Wilbur, former Secretary of the Interior and former president of the AMA. The financial support came from eight philanthropic foundations—Carnegie Corporation, Josiah Macy, Jr. Foundation, Milbank Memorial Fund, Russell Sage Foundation, the Twentieth Century Fund, and the Julius Rosenwald Fund. The Committee published 26 major volumes covering data regarding the incidence of diseases, the number and adequacy of medical facilities, and the cost of medical care. These reports constituted the most comprehensive survey of its kind ever carried out in this country.  

Ibid., 109-127.  

S. M. Hamill, "Activities of the State Emergency Child Health Committee," paper read before the Montgomery County Medical Society, March 22, 1933, Children's Bureau Papers, National Records Center, Suitland, Maryland, Group Number 363, Box 158. Hereafter the Children's Bureau Papers are indicated by the symbol CBP, followed by the National Record Center (NR) and the Record Group Number (RG).  


Ibid., 4-9.  


Ibid., 11.  


Ibid., 2.  

Children's Bureau, Proceedings, pp. 11-23.  

In the summer of 1933 the Federal Emergency Relief Administration authorized state relief administrators to use federal funds for medical care. Under this arrangement, medical care was given to children as well as adults in families on relief, but such medical care had to be limited to acute conditions or to correcting conditions interfering with growth.

Grace Abbott, The Child and the State, Vol. II (Chicago, 1938), p. 240. This provision was later struck out before passage of the bill. Miss Abbott said: "There was much objection to federal determination of adequacy on the part of Southern members who feared that Northern standards would be forced on the South in providing for Negro and white tenant families.

Executive Order No. 6757.

In November, 1934, President Roosevelt named Miss Katherine F. Lenroot the new head of the Children's Bureau. Miss Lenroot who had been with the Bureau since 1915 served during the remainder of the Depression, the war years, and the immediate post-war years.
Executive Order No. 6777. On June 30, 1934, the day following the creation of the Committee on Economic Security, President Roosevelt issued Executive Order No. 6777 which established the Advisory Council and the National Resources Board. The National Resources Board was given the function of developing the natural resources of the nation to provide full employment.

Witte, Social Security, pp. 43-46.

Ibid., p. 60-61.

Sobid., pp. 60-61.


Witte, Social Security, pp. 67-68.

Ibid., pp. 68-69.


Ibid., p. 3.

Ibid., p. 38.


Ibid.

The decision to submit the Social Security bill to the House Ways and Means Committee was interpreted by some as a deliberate move on the part of the Administration to circumvent the radical tendencies of the Labor Committee; Paul H. Douglas, Social Security in the United States (New York, 1936), p. 85.

U.S. Congress, House, H.R. 4142 (A bill to alleviate the hazards of old age, unemployment, illness, and dependency, to establish a Social Insurance Board in the Department of Labor, to raise revenue, and for other purposes), 74 Cong., 1 Sess. (1935).
The testimony given before these two Congressional Committees is contained in two published volumes, viz; Senate, Hearings on Social Security and House, Hearings on Social Security.

Witte, Social Security, p. 167.

House, Hearings on Social Security.

Ibid., p. 263.

The work of redrafting the bill was done by Middleton Besman, House Legislative Council, with the help of Thomas H. Eliot, draftsman of the original version; Witte, Social Security, p. 101.


Witte, Social Security, p. 108.

Ibid., p. 12.

Ibid., p. 42.

Congressional Record, 74 Cong., 1 Sess. (1935), LXXIX, Pt. 5, p. 5467.

Ibid., p. 6095.

Ibid., pp. 6267-6268.

Ibid., pp. 6059-6070.


Ibid., pp. 3-4, 16-20.

Ibid., pp. 72-77.

Ibid., pp. 52-54.

Congressional Record, 74 Cong., 1 Sess. (1935), LXXIX, Pt. 9, p. 9631.
Title I Grants to States for Old Age Assistance.

III Grants to States for Unemployment Compensation Administration.

IV Grants to States for Dependent Children.


VI Public Health Work.

VII Social Security Board.

VIII Taxes with Respect to Employment.

IX Taxes on Employers of Eight or More.

X Grants to States for Aid to the Blind.

XI General Provisions.

U.S. Statutes at Large, XXXXIX, Part I, pp. 620-647.

Title V includes: Part I, Maternal and Child Health Services; Part 2, Services for Crippled Children; Part 3, Child Welfare Services, to be administered by the Children's Bureau, U.S. Department of Labor; and Part 4, Vocational Rehabilitation, to be administered by the Federal agency dealing with vocational rehabilitation, the Office of Education, U.S. Department of the Interior.

Social Security Act.

The U.S. Congress limited the duration of the Sheppard-Towner Act to only seven years.


CHAPTER III

LAUNCHING THE CHILD HEALTH SERVICES:

THE FIRST FIVE YEARS

After the passage of the Social Security Act, much of the Children's Bureau time and effort was devoted to the development of standards and policies for the state administration of the maternal and child health and crippled children's programs. First the Children's Bureau created two new divisions within the Bureau to administer parts one and two of Title V. Next, the Bureau turned to state administrators and advisory groups of professionals to help formulate its policies and recommendations to the responsible state agencies, with respect to the content and quality of these programs.

A maternal and Child Health Division and a Crippled Children's Division in the Children's Bureau were established, under the immediate supervision of Dr. Martha M. Eliot, Assistant Chief of the Children's Bureau, to administer the grants-in-aid to the states and to aid the state health departments develop effective programs. Through these divisions the services of regional medical consultants, pediatricians, obstetricians, public health nurses, and nutritionists were made available to the states for consultation under Title V.

The Secretary of Labor appointed a General Advisory Committee on Maternal and Child Welfare to develop general policies for the administration of Title V, parts one, two, and three, of the Social
Security Act; the General Advisory Committee consisted of representa-
tives of medicine, public health, nursing, social work, and lay
groups.\(^1\) In addition, a Committee on Maternal and Child Health,
composed of 58 members from the fields of general medicine, obstetrics,
pediatrics, psychiatry, dentistry, nursing, public health administra-
tion, and hospital administration was created.\(^2\) Subcommittees, one on
maternal health and one on child health, were appointed from the
medical members of the main committee. A third advisory committee to
deal with programs for crippled children, comprised 38 members from
many of the special fields of orthopedic surgery, pediatrics, hospital
administration, public health nursing, physical therapy, medical-
social work, education, vocation-rehabilitation.\(^3\) In 1939, selected
members of the committee were appointed as a special subcommittee on
rheumatic fever.

On December 16 and 17, 1935, the Advisory Committee on Maternal
and Child Welfare met in Washington and made recommendations concerning
the plans to be formulated by the states for submission to the Chil-
dren's Bureau. The Advisory Committee proposed the following guide-
lines:

It was the consensus that there should be in the state depart-
ment of health a division of maternal and child health or a
comparable administrative unit, coordinate with all other adminis-
trative divisions, with a director responsible to the health
officer. It was further suggested that the director should be a
physician.

As regard participation in a maternal and child health program
by local or other qualified physicians, the committee was of the
opinion that such services should be arranged for jointly by the
local health department and the local medical association, with the
advice of the director of the state division of maternal and child
health.

It was the opinion of the Committee that as far as possible
the maternal and child health work . . . should be carried on by
local qualified physicians . . .

The Committee was of the opinion that physicians performing
services under that act should receive remuneration for such
services and that policies governing such remuneration should be
worked out jointly by the state and local medical societies and
the state agency administering the program. The Committee recom-
manded that the states set up professional advisory committees
representing the medical, nursing, physical therapist, and social
work interests.4

Following the December meeting of the Advisory Committee, the
Children's Bureau promulgated a policy which required the state
administration of the programs to be organized in distinct units of
the state health agency under the direction of a physician responsible
directly to the state health officer. Experience under the Sheppard-
Towner Act had shown that maintenance of standards required state
maternal and child health and crippled children's programs to be under
the direction of a person who was a graduate in medicine. At the same
time, the Bureau found it necessary to define certain provisions of
the Act, such as "demonstration services." On June 6 and 7, 1936, the
Bureau held a conference of state directors of maternal and child
health divisions. The primary purpose of the conference was to famil-
iliarize the state directors with Bureau policies and discuss mutual
problems.5

At the first meeting of the Advisory Committee on Services for
Crippled Children in December, 1935, it was recommended that only
surgeons certified or eligible for certification by the American Board
of Orthopedic Surgery should be approved by the state agency for
service to children suffering from orthopedic conditions and that
other physicians employed should be certified or eligible for certifi-
cation by the national boards in their specialties.6
The 1936 report of this Committee recommended among other items: direction of medical programs by physicians; establishment in state departments of health of a separate bureau for services for crippled children; appointment of technical advisory committees; cooperation of agencies administering services for crippled children with various related groups; provisions for an educational program for physicians, parents, and personnel; programs of prevention of crippling; establishment of standards for hospital care based on information from the American College of Surgeons, the American Hospital Association, and the American Medical Association, and establishment of standards for the qualifications of surgeons, nurses, physical therapists, and medical social workers, based on the recommendations of nationally recognized organizations in their respective fields after consultation with the technical advisory subcommittees to the state programs. Prior to the development of the nationwide services for crippled children most state agencies which were administering crippled children services had not assumed responsibility for establishing standards for the selection of hospitals to be used for the care of crippled children.

In 1935, Dr. Martha M. Eliot was appointed director of the Bureau's Maternal and Child Health Division. Dr. Eliot, one of the architects of Title V, patiently negotiated with each state health agency in an attempt to implement the programs. Her ability to use administrative procedures and appropriations of the Social Security Act with the maximum impact contributed greatly to the success of the state programs. In the last half of the decade she stimulated the
development of more comprehensive, inclusive services for mothers and infants throughout the nation, and she developed as part of Title V new methods in which better care could be purchased with federal and state funds. Under her direction, the Bureau put great stress on the need for close relationship between research and services for children. In addition, she tirelessly sponsored legislation designed to expand child health services.  

In February, 1936, Congress passed the Supplemental Appropriations Act for fiscal year 1936, which provided for funds to carry out the provisions of the Social Security Act. By November, 1936, all 48 states, plus the District of Columbia, Hawaii, and Alaska had submitted plans for maternal and child health, the plans had been approved, and the states were receiving federal funds. Plans for services to crippled children had been approved for 36 states, Alaska, and the District of Columbia.  

By the end of the year, all the states had developed administrative units which started functioning to promote the health of mothers and children. Only six states were unable to take up their full share of the available federal funds because of the inability to obtain state funds for matching purposes. The states that could not match federal funds were chiefly those which had not provided maternal and child health services before the passage of the Social Security Act; and by the end of 1937, the first full year of operation, considerable progress had been made by the states in developing prenatal clinics, postnatal service, infant and pre-school conferences, school health services, dental services, and special training and post-graduate
education for physicians.

The progress reports of the state health officers for the calendar year 1937 gave some indication of the maternal and child health activities under the federal-state cooperative programs. Physicians gave medical examinations to expectant mothers in prenatal clinics established in 408 counties over 35 states; postpartum examinations were provided in 391 local districts in 33 states; child health conferences were held in 685 counties in 38 states in 1937. Two thousand and five hundred and fourteen practicing physicians conducted health conferences and examinations of school children in 708 local districts in 41 states. These examinations were made by local doctors paid wholly or partly from maternal and child health funds. In 18 states obstetricians or pediatricians were employed on a fulltime salary basis for the purpose of assisting general medical practitioners.

More than 50 percent of the federal, state, and local funds in the budgets for the state maternal and child health programs were designated for the employment of public health nurses. The use of these funds enabled the states to employ more than 2,700 public health nurses. Almost all of these nurses rendered generalized services, placing emphasis on home visits for instruction in maternal and child care, school health supervision and instruction, assistance at prenatal clinics and child health conferences, and the organization of local child health councils and committees.

Dental services were offered in conjunction with maternal and child health programs in 14 states. The major emphasis was on
preventive dentistry and dental education. In 1937, 13 states provided dental services at prenatal and child health conferences. Furthermore, post-graduate training was provided with the aid of maternal and child health funds for a limited number of physicians, nurses, and dentists in 34 states. Some state agencies strengthened their administrative personnel by training 23 physicians and 305 staff nurses, and courses in obstetrics for local practicing physicians were held in 316 centers in 32 states and courses in pediatrics were held in 243 centers in 26 states. In addition, 163 dentists received post-graduate training in seven centers in two states.

Prior to the passage of the Social Security Act in 1935, public provisions for the care of crippled children were sporadic and uneven and in many states totally inadequate or even nonexistent. Only 28 states had an official state agency authorized by law to provide care and medical treatment for crippled children. In many of these states appropriations were small and services limited.

By June 30, 1936, state plans had been approved for the administration of services for crippled children for 38 states. At the close of the fiscal year 1937, every state had designated an official agency to administer services for crippled children and state plans had been approved for 42 states and Alaska, Hawaii, and the District of Columbia. Some indication of the extent of services to crippled children during the first full year of operation is shown by the following figures taken from reports of state health officers. A total of 77,055 crippled children were reported in attendance at crippled
children clinics; 42,073 children received surgical and medical care in hospitals; 5,168 children were cared for in convalescent homes and 1,107 in foster homes. The states reported 212,248 home and office visits by public health nurses, 187,250 visits by physical therapy technicians, and 63,370 visits by medical social workers and other social workers in the last six months of 1937.

The availability of federal funds enabled states to establish more effective methods for locating crippled children, to extend their diagnostic clinical services, to improve the quality of medical care through the employment of orthopedic surgeons and other specialists, and to develop more diversified services for crippled children.

As concrete evidence of the widespread interest in maternal and child health, Dr. Felix J. Underwood, in his 1937 Joint Report of the Committee on Maternal and Child Health of the State and Territorial Health Officers and the Child Hygiene Committee of the State and Provincial Health Authorities, pointed out that nearly 15 percent of the $42,000,000 spent by state health authorities that year was spent for maternal and child health care plus the care of crippled children.

He further stated that 80 percent of this amount was spent for work in the field, with a relatively small amount expended for supporting central administration.

With the extension of maternal and child health services, the maternal mortality rate declined from 57 deaths per 10,000 live births in 1936 to 49 in 1937. The infant mortality rate decreased from 57 deaths per 1,000 live births in 1936 to 54 in 1937.

Early in 1937 the Children's Bureau General Advisory Committee
on Maternal and Child Welfare Services met in Washington to consider problems concerning content of programs and policies with respect to the Administration of Title V, parts 1, 2, and 3 of the Act. Following an opening session at which Miss Katherine Lenroot, Chief of the Children's Bureau, gave a short general report, the members of the General Advisory Committee received progress reports and recommendations from three special advisory committees on maternal and child-health services, services for crippled children, and child-welfare services.27 The recommendations adopted by the General Advisory Committee covered three aspects of maternal and child care, namely:

1. Extension of the maternal and child-health work begun in 1935 through federal cooperation with the states under the Social Security Act. This requires appropriations of public funds for maternal care, medical and nursing, for all women in need of such care, considering need as including not alone economic but also medical needs and lack or inadequacy of existing facilities.

2. The establishment of a center or centers of post-graduate education to teach urban and rural practitioners of medicine and nurses the fundamental principles of complete maternal and infant care.

3. The necessity and desirability of cooperation with the national, state, and local medical societies in the working out of any plan.28

In its report on services for crippled children, the Advisory Committee urged that the Children's Bureau assist state agencies in reviewing the type of care given crippled children in hospitals and reaffirmed its previous recommendations concerning desirable qualifications of surgeons and other medical personnel employed by state agencies.29 The Committee recommended no new extension of convalescent facilities and after-care services and emphasized the need for the registration for crippled children. The Committee also suggested that state agencies reporting crippling conditions should use the
classification system of types of crippling prepared by the Children's Bureau.\(^30\)

In April, following the Conference of the General Advisory Committee, the State and Territorial Health Officers, and the State and Provisional Health Authorities made a report to the President in which they recommended increased maternity and infant care.\(^31\) The American Public Health Association and the American Legion adopted similar recommendations at their annual conventions.

In October, 1937, Miss Lenroot, after reviewing the recommendations of the Advisory Committee, called a small conference of representatives of national organizations to consider the problems of maternal and child care. The consensus of the conference was that a larger and more representative group should be convened in January, 1938, to consider "existing resources for the care of maternal and newborn infants in the United States, the extent to which maternal and infant mortality may be reduced, the measures successfully undertaken in certain localities and among certain groups, and the ways by which such services may be made available to everyone."\(^32\) An executive committee representing 46 national organizations did the preliminary planning for the conference on health care for mothers and infants.\(^33\)

The Conference on Better Care for Mothers and Babies was called in Washington on January 17 and 18, 1938. A total of 481 delegates from 45 states, Alaska, Hawaii, and the District of Columbia representing 86 national organizations attended the conference. Professional associations, federal, state, and local health officials, state welfare directors, chairmen of state advisory committees on maternal
child health services, and presidents of the state pediatric committees of state medical societies attended the conference and participated in the discussions.34

The material collected by the Children's Bureau as the basis for the Conference discussions showed that there had been no substantial reduction of the maternal mortality rate during the 22 years for which records were available. The death rate for infants in the first year of life had steadily declined for the same 22 year period, but there had been little decline in the death rate for the first month of life (which accounted for almost half the total mortality in the first year). Other shocking facts were revealed at the conference--insufficient and often incompetent medical, nursing, and hospital care; economic underprivilege of the third of the population which was having the most children; and a total lack of medical facilities for large numbers of rural women.

Three committees--on Professional Recourses, Community Resources of Citizens Groups, and General Findings--prepared reports which were presented to the final session of the Conference on January 18, 1938. The Committee on Community Resources recommended that professional staff administering a state maternal and child health program should include a staff of qualified public health nurses, with a director and regional assistants to administer and supervise the public health nurses in the field.35 The General Findings Committee recommended "full opportunity for practical instruction in obstetrics and the care of newborn infants for undergraduate students in medical schools, for resident physicians in hospitals, and periodically for
practicing physicians in post-graduate courses; for the student nurse and at recurrent intervals for the graduate nurse or the public health nurse whose work includes maternity nursing in private practice or in public health service." The Committee on Professional Resources also urged "every effort be made by the obstetric specialist and those interested in maternal welfare in the United States to reduce the number of unnecessary or ill advised obstetric operations which play such an important part in maternal mortality." 

The Committee on Community Resources called for infant and maternal care provisions by local communities as part of its public health responsibility, and recommended adequate federal subsidy to state and local communities in order to equalize the financial burden of health needs. Such federal participation, it found, would require an amendment to Title V, Section 502 of the Social Security Act "to authorize a larger sum to be appropriated annually to the state for maternal and child health services with provision that the increased payments to the states should be used for the improvement of maternal care and care of newborn infants." The Committee did not attempt to set figures but held that appropriations should be increased until they provide a sum that insure medical care for all women. At the close of the Conference on January 18, a special committee consisting of Miss Katherine Lenroot, Dr. Fred L. Adair, Dr. M. Eliot, Mrs. J. K. Pettengill, Mrs. Charles W. Sewell, and Dr. Felix J. Underwood presented the reports of the various committees to the President.

During the fall and winter of 1935-36, the U.S. Public Health Service with the aid of grants from the Works Progress Administration
conducted a house-to-house canvas of 703,092 urban families in 18 states and 36,801 families in certain rural areas. The study was conducted to determine the frequency of serious disabling illness, the medical services received in connection with these illnesses, and the relation of these items to social and economic conditions. The National Health Survey indicated that a large proportion of the urban population had incomes which left little or no margin for unexpected or large medical costs, that illness rates were highest in the income groups least able to meet medical costs; that, in general, persons on the lowest levels received the least medical care; and that these persons, when living in smaller cities, were especially disadvantaged compared to their counterparts in larger cities, especially with regard to hospitalization. The Survey revealed that one-third of all illnesses occurred among children under 15 years of age, and that eight children in every 1,000 of the population under 21 years of age had been disabled by permanent orthopedic impairments. It also found that more than 500,000 women were delivered in 1935 without the advantage of a physician's care.

The Survey contributed some additional data concerning the prevalence of orthopedic conditions. The findings indicated that there were at the time of the survey "over 210,000 children (120,000 boys and 90,000 girls) under 15 years of age with these afflictions, almost 1,900,000 adolescents and adults between the ages of 15 and 64 years, and 500,000 older persons." In short, the National Health Survey drew the attention of the Interdepartmental Committee to Coordinate Health and Welfare Activities to the health care problems of the nation.
After the passage of the Social Security Act, President Roosevelt, in August, 1935, appointed the Interdepartmental Committee to Coordinate Health and Welfare Activities "in order that the provisions might reach within minimum delay and maximum effectiveness ... (those) for whose aid the program was brought into existence."44

Early in 1937, the Interdepartmental Committee created a subcommittee, The Technical Committee on Medical Care, made up of experts from the Public Health Service, Children's Bureau, and Social Security Board. Dr. Martha Eliot, Assistant Chief of the Children's Bureau, was appointed chairman of the Technical Committee.

In September the Interdepartmental Committee asked the Technical Committee to study the National Health Survey, to correlate these results with other data on the participation of the federal government in the health services of the nation, and to submit recommendations on federal participation in a National Health Program. After eight months of intensive work, the Technical Committee submitted its report entitled "The Need for a National Health Program." The report cited four major deficiencies in the health services of the United States: (1) preventive health services of the United States were grossly insufficient; (2) hospital and other medical faculties were inadequate in rural areas, and financial support for hospital and professional services in hospitals were insufficient and precarious; (3) one-third of the population was receiving inadequate or no medical service; and (4) an even larger fraction of the population was suffering from economic burdens created by illness.45

The report placed primary emphasis on the excessive and needless
waste of the lives of mothers and infants, and the prevalent illness of children. In connection with the high maternal and infant mortality rates, it insisted:

The deaths of women in childbirth present a special challenge; with adequate care from one-half to two-thirds of these deaths could be prevented.

Mortality of infants during the second to the twelfth month of life, though showing consistent decline, might be further reduced in the first month of life; these deaths also may be reduced by as much as one-half with adequate care of mother and child.

The death rates from the acute communicable diseases of childhood have been greatly reduced; further reduction can be brought about by the application of known measures of prevention and cure.

The Technical Committee on Medical Care also recognized in its report the limitations of the Crippled Children Program. The Committee estimated that in the Northeastern states of the country at least 1 percent of the school children had rheumatic heart disease, approximately 30 percent of all children under 15 years of age had defective vision, approximately 5 percent of the school children had impaired hearing, and approximately two-thirds of all school children had dental defects. After recognizing the progress under the Social Security Act in making available for crippled children orthopedic and plastic surgical service, hospitalization and aftercare, the Committee stated the need of further provision for children crippled or handicapped from heart disease, diabetes, congenital syphilis, injury due to accident; the need for facilities for hospital and convalescent care for children with early rheumatic heart disease; and the need of early discovery and treatment of children with visual, auditory and dental defects. The Committee recommended that Title V, Part 2 of the Social Security Act be amended to increase the annual grants to the states of a ten year program and by not less than $5,000,000 by the fifth year.
To cope with these needs, the Technical Committee submitted broad recommendations early in 1938 to expand maternal and child health services. These recommendations dealt with specific diseases and provided for increased expenditures on a federal-state cooperative basis, within the framework of the social security system.

Federal grants-in-aid would be increased steadily over a 10 year period with the expectation that at the end of the tenth year the federal government would provide grants in the amount of $80,000,000 annually. The expanded program would include the provisions of medical and nursing care of mothers and their newborn infants and medical care of children. The Technical Committee proposed that hospital facilities be expanded through government aid, that insurance be provided against the loss of wages during illness, and that a "general program of medical care" be instituted.47

The report of the Technical Committee was considered in detail by the Interdepartmental Committee, adopted, and sent to President Roosevelt on February 14, 1938.

On March 8, 1938, President Roosevelt suggested in a letter to Josephine Roche, Chairman of the Interdepartmental Committee, that a National Health Conference be called to consider the needs which had been revealed by the Technical Committee. He proposed that the Interdepartmental Committee should invite "representatives of the interested public and of the Medical and other professions, to examine the health problems . . . ."48

The National Health Conference met in Washington on July 18 to 20, 1938. Of those who were invited to the conference, a total of 176
attended. This group represented labor, agriculture, industry, women's organizations, civic bodies, social and public welfare workers, organized medicine, hospital administrators, nurses, and public health workers.

The government presented the Technical Committee's Report to the National Health Conference as basis for discussion but no attempt was made to reach consensus with respect to these recommendations. A large majority of the participants—especially those representing labor, agriculture, and women's organizations—were united in their recognition of their recognition of the unmet needs and in favoring governmental action to meet them. Miss Lenroot reminded the conference:

In planning health service, as in meeting mass disaster, the needs of mothers and children require that they be among the first to be cared for. The extension and coordination of health, welfare, and educational services for them and for young people ready to enter the ranks of productive workers will reduce death and illness, school failure, and social breakdown among that portion of our population which in a few years will be determining the policies and carrying on the civic, vocational, and home activities of the nation.49

At the close of the National Health Conference, the Interdepartmental Committee asked delegates to carry the recommendation back to their organizations.50

The recommendations of the Technical Committee stimulated considerable discussion of health problems.51 During September, 1938, the House of Delegates of the American Medical Association was called into special session in Chicago to consider the specific proposals of the Committee. The Representatives of the AMA vigorously objected to compulsory health insurance, arguing that there was no need for government intervention since the medical profession itself was prepared to
provide for any medical problems which might arise. Although opposing a national health program, the House of Delegates, the governing body of the AMA, voted unanimously to adopt a report that broadly endorsed the recommendation relating to the expansion of maternal and child health services. The American Public Health Association, at its annual meeting in Chicago, on October 25 through 28, followed suit by expressing support of the Technical Committee's Report.

The National Health Survey and The National Health Conference provided mounting evidence that there was a need for continued federal-state cooperation in the field of maternal and child health care if all Americans were to be adequately protected against illness. The development of the National Health Insurance movement in the United States greatly strengthened the efforts of the Children's Bureau to improve child health care.

Late in 1938 in a review of the accomplishments of the Social Security Act, Dr. Martha M. Eliot, then Assistant Chief of the Children's Bureau, Jessie Bierman, and A. L. Van Horn, who were responsible for the maternal and child health and crippled children's program, urged extension of these programs to provide additional medical services to mothers and children. "The utter futility," they wrote, "of providing means of assessing the health and welfare of children and of mothers, and of not providing the means to maintain them in health or to restore them to health if sick, or in the case of maternity to make available complete medical and nursing care of mothers and infant, has forced itself upon health and welfare worker and upon the people . . . ." As for crippled children's services, they declared that funds were "wholly
inadequate" to meet the need to include such conditions as rheumatic fever, rheumatic heart disease, and impairment of vision and hearing, or to improve the notably inadequate care of the "hopelessly" crippled child.

Following the close of the National Health Conference, the Interdepartmental Committee, utilizing information gained at the Conference, submitted a proposed National Health Program to the President on January 12, 1939. In this report the Committee recommended that existing federal-state cooperative health programs under the Social Security Act be expanded, that grants-in-aid be made to the states for the construction of hospitals, and that a disability insurance be established under federal supervision.

President Roosevelt transmitted the report to Congress together with a special message urging that it be given careful consideration. On February 23, 1939, Senator Robert Wagner of New York introduced a bill (S. 1620) designed to implement the Interdepartmental Committee's recommendations. The Wagner Bill provided for the establishment of an integrated national health program through amendments of Titles V, VI, and XI and the additions of three new titles—XII, XIII, and XIV—to the Act. The operation of the health and medical care programs were to be left up to the states; the function of the federal government was to encourage state establishment of its own program through the provision of financial and technical aid.

The proposed amendment of Title V provided for expansion and strengthening of the federal-state cooperative programs for maternal and child health, including services for crippled children. The bill
authorized substantially increased grants, to begin at $8,000,000 (fiscal year 1940) for maternal and child health services and to increase gradually over a 10 year period. For service to crippled children and other physically handicapped children, the Wagner bill allotted $4,000,000 in the fiscal year 1940, $5,000,000 in the fiscal year 1941, and thereafter so much as the chief of the Children's Bureau deemed necessary.

The Wagner bill made minor changes in the language of sections 504 and 514 of Title V for the purpose of simplifying payment to the states. An amendment of the allotment provision of the Title (section 502 and 512) limited the availability of funds appropriated for a fiscal year to a single additional year instead of two additional fiscal years as was the case in the social security law and made unexpended funds in the federal treasury subject to reallocation. It was suggested that the proposed amendment of Title V of the Social Security Act include provision for joint conferences by the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Chairman of the Social Security Board.58

During the later part of 1938, the Children's Bureau became increasingly concerned with the risk of tying the program too closely to the National Health Program. Dr. Eliot sensed that the compulsory health insurance proposal would encounter strong congressional opposition, unless this part of the program was modified. She feared a defeat of the National Health Program might damage the Bureau's child health program; therefore, the Children's Bureau requested the Social Security Board to moderate its recommendation in the proposed Wagner
Although the Children's Bureau enthusiastically endorsed S. 1620, it recommended two changes. The Bureau suggested the creation of a single advisory National Health Council to be composed of approximately 15 to 21 members appointed jointly by the Chief of the Children's Bureau, the Surgeon General, and the Social Security Board. This National Health Council was to replace the federal advisory councils authorized under sections 506 and 516 of Title V of the Wagner bill. The Children's Bureau further proposed that provision be made for joint consultation by the Chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Social Security Board in order to develop uniformity in requirements for the submission of budgets, accounts and reports by the cooperating state agencies.

The bill was sent to the Committee on Education and Labor from which it was referred to a subcommittee for study and recommendations concerning disposal of the measure. The subcommittee held extensive hearings from April to July of 1939. During the course of these hearings, a large volume of testimony and supplementary information was acquired.

Miss Lenroot, the Chief of the Children's Bureau, expressed her sympathies with the objectives of the bill. At the hearings, she testified that two-thirds of the maternal deaths and at least one-half of infants deaths could be avoided. She asserted that hospital facilities for the care of maternal patients was grossly inadequate in many rural areas. Dr. Martha M. Eliot in her testimony indicated that
funds for medical care for crippled children under Title V were totally inadequate to meet the needs of the states even for orthopedically crippled children. Dr. Eliot stated that it was not possible to supply care for children crippled by heart disease, blindness or deafness, or to provide services for many children who developed crippling conditions as a result of accidents.62

In August 1939, Senator James E. Murray, Chairman of the Subcommittee, presented a preliminary report to the Senate which endorsed the general bill but called for further consideration by the Committee on Education and Labor and for additional consultation with lay and medical organizations. The Committee concluded:

A critical analysis of the present provisions of S. 1620 shows a number of points at which its specific purposes can be more clearly stated and its provisions improved. Some misunderstandings seem to have arisen and criticisms have been expressed concerning parts of the bill. Some witnesses have assumed that it would bring about revolutionary or dangerous changes in medical care. We think these fears are unwarranted, but we will welcome further suggestions as to specific amendments which may safeguard the objectives of the bill. Medical science has reached a commendable status in this country. The bill should encourage the further evolutionary development of medical science, teaching, and practice.63

Although it was expected that the bill would be reported out during the following session of Congress, this hope did not materialize. Instead, the administration definitely shelved the National Health Program, and along with it the hope of expanding the maternal and child health program of the federal government.64

The failure of the Wagner bill did not signal the end of the attempt to expand maternal and child health services and services for crippled children. On April 8, 1938, the Conference of State and
Territorial Health Officers approved a draft of the bill to amend Title V, part of the Social Security Act so as to provide enlarged service during maternity and infant care. A measure was introduced in the Senate by Senator Barkley on April 20, 1938 (S. 3914) and in the House by Mr. Doughton on April 12, 1938 (H.R. 10241) which provided for additional sums under Title V, part in the amount of $3,000,000 for the fiscal year 1939; $8,000,000 for the fiscal year 1940; $12,000,000 for the fiscal year 1941; $16,000,000 for the fiscal year 1942; and $20,000,000 for the fiscal year 1943 with additional funds "thereafter as may be needed to carry out the purposes of the title." Because the bill was introduced late in the session, no action was taken.

On April 28, 1938, President Roosevelt wrote a letter to Mr. Altmeyer, Chairman of the Social Security Board, stating in part, "I am very anxious that in the press of administrative duties the Social Security Board will not lose sight of the necessity of studying ways and means of improving and extending the provisions of the Social Security Act." He ended the letter by saying that he hoped that the Social Security Board would be prepared to submit recommendations before Congress convened in January. On December 30, 1938, the recommendation of the Board, based on intensive study and experience, were submitted to the President.

On January 16, 1939, President Roosevelt transmitted to the Congress the Social Security Board's report and his own proposed changes "that the states be required as a condition for the receipt of federal funds to establish and maintain a merit system for the selection of personnel." This message and the Board's report were
referred to the House Ways and Means Committee.

A subcommittee of the House Ways and Means Committee held extensive hearings on these recommendations and alternative proposals relating to Social Security and submitted a favorable report to the House on June 2, 1939. On the same date, H.R. 6635 was introduced incorporating the recommendations of the Committee. With respect to Title V, the bill amended the maternal, child health, and crippled children provision "so as to make clear that the method of administration of a state plan would be proper as well as efficient." This change was "similar to that made in the corresponding provision of Titles I, IV, and X." The bill also provided for extending to Puerto Rico the provision of Title V, increased the amount authorized for "Fund A" for such services by one million dollars. This bill passed the House on June 12 by a recorded vote of 103 to 52 and was referred to the Senate Finance Committee.

In the meantime, on January 23, the President sent to the Congress a message on health security, accompanied by the report and recommendations on national health prepared by the Interdepartmental Committee to Coordinate Health and Welfare Activities. One of the recommendations of this committee was "the expansion of existing cooperative programs under Title VI (Public Health Works) and Title V (Maternal and Child Health and Welfare) of the Social Security Act."

With respect to Title V, the report stated:

The objective sought in this phase of the committee's proposed program is to make available to mothers and children of all income groups and in all parts of the United States minimum medical services essential for the reduction of our needlessly high maternal rates and death rates among new born infants, and for the
prevention in childhood of diseases and conditions leading to serious disability in later years. On February 28, 1939, Senator Wagner introduced S. 1620, a bill "to provide several states to make more adequate provision for public health prevention and control of disease, maternal and child health services, construction and maintenance of needed hospitals and health centers, care of the sick, disability insurance, and training of personnel," to amend the Social Security Act and for other purposes. On April 27, the Subcommittee on S. 1620 of the Senate Committee on Education and Labor began extended hearings on this bill, which were not ended until July. Testimony presented to the Senate Committee on Education and Labor in hearings on S. 1620, the National Health bill, by the Chief and Assistant Chief of the Children's Bureau, indicated the urgent need for expansion of maternal and child health care as well as crippled children programs.

The Senate Finance Committee reported out H.R. 6635 on July 7, 1939. The principal contents of the bill as reported out of the Committee were as follows:

1. Provision is made for a $2,020,000 increase in the authorization for federal grants to the states for maternal and child health services. This will increase the present federal authorization from $3,800,000 to $5,820,000.

2. Provision is made for a $1,020,000 increase in the authorization for federal grants to the states for crippled children. This will increase the present federal authorization from $2,850,000 to $3,870,000.

In discussing these proposed changes, the report noted that the Senate Committee hearings demonstrated an urgent need for increased funding for maternal and child health and crippled children services under Title V, part 1 and 2 of the Social Security Act. In her
testimony before the Committee, Dr. Martha M. Eliot stated that an additional $7,000,000 was needed for fiscal year 1940 to carry forward programs already initiated by the states. Dr. Eliot stated that over 14,500 crippled children were on the waiting lists of the official state agencies, awaiting hospital care and that nearly 13,000 were awaiting care because of a lack of funds. In addition to crippled children on the waiting lists, there were large numbers of crippled children suffering from heart disease who should have been brought within the program. On July 13, H.R. 6635 passed the Senate and on August 10, it was signed by the President. This bill became Public Law 379.

As finally enacted, the 1939 amendment made the following changes in Title V of the Social Security Act:

1. Increased the amount authorized for each of the programs to the following:

   Maternal and Child Health Services ............................................. $5,820,000
   Crippled Children Services ............................................................... $3,870,000

No changes were made in the amounts of the uniform grants for Maternal and Child Health and Crippled Children services. They remained at the amounts originally enacted, namely $20,000 in each program. Under the original act, the amounts for "Fund A" and "Fund B" for Maternal and Child Health Services were $2,820,000 and $980,000, respectively. These amounts were changed by the 1939 amendment to $3,820,000 and $1,980,000 respectively with respect to crippled children services, for which a "Fund B" provision was added by the 1939 Amendments; the amount for "Fund A" and "Fund B" were $2,870,000 and $1,000,000 respectively.

2. Added new provision for "Fund B" in crippled children services grants.
3. Added new provision enabling Puerto Rico to participate in all three grant programs.
4. Added merit system provision as condition of plan approval for Maternal and Child Health and Crippled Children grants.

The use of these additional maternal and child health funds resulted not only in continued expansion of the established preventive
services but in the development of corrective medical and hospital care. For example, by 1940, 19 states expanded maternal and child health funds for such services as medical care of maternity patients including delivery, medical care for sick children, corrective dental care of children, hospital care, and clinical case consultation by pediatric and obstetric specialists. These programs were small because of financial limitations, and were created on a demonstration basis only. The number of these demonstration programs increased through the fiscal year 1942. Local and state health agencies evidenced increased interest in these programs, but with the beginning of the war and the loss of professional personnel to the armed forces, most of the special projects were abandoned.

Congress had increased the appropriation for crippled children program with the understanding that part of these funds would be used by the states to develop services for children with rheumatic heart disease. As a first step in inaugurating a rheumatic heart disease program, the Children's Bureau called a conference of pediatricians for the purpose of outlining general policies and recommendations. The Bureau added to its staff a cardiac consultant, Dr. Betty Huse. In order to provide training for physicians and nurses to treat rheumatic fever, the Children's Bureau in 1941 sponsored a six-weeks teaching program jointly with the Cornell Medical College and the New York Hospital. By November, 1942, 14 states had rheumatic fever programs in operation, and several additional states were developing plans.

Furthermore, the Social Security Act Amendments included the provision that the state plans for services to children after January 1,
1940, should include provision for the establishment and maintenance of personnel standards on a merit basis.

Under the original Act, the Children's Bureau could not approve a state plan unless there was provision for "such methods of administration" as were found by the Bureau to be necessary for "efficient operation." Provisions relating to the selection, "tenure of office, and compensation of personnel" were exempted. The new provision required that participating states establish and maintain certain personnel standards on a merit basis. Under this provision the Children's Bureau had no authority with respect to the selection, tenure of office, and compensation of any individual employee. This requirement was effective after January 1, 1940.79

For the guidance of the state agencies responsible for the Administration of Maternal and Child Health Services and services for crippled children in developing merit systems, the Children's Bureau had prepared a statement of "Recommended Standards for the Establishment and Maintenance of a Merit System of Personnel also Administration."80 The Bureau also issued a statement of qualifications recommended for certain classes of professional personnel to be employed in the state programs. These recommended qualifications had been developed after consideration of the standards adopted by the Conference of State and Territorial Health Officers and by the Children's Bureau Advisory Committees, together with the AMA, ANA, and ADA. By March 1, 1940, every state crippled children's agency but one had adopted standards for the development of its merit system, and by July 1 every state maternal and child health agency but two had approved rules and
regulations for the development of a merit system.

The attention of the Children's Bureau and groups interested in children was focused for three days, January 18 through 20, 1940, on the White House Conference on Children in a Democracy. Beginning in November, 1939, the planning staff for the White House Conference on Children had called upon the research of experts in the field of child development. It was decided to extend the purposes of the Conference to include, as the President stated, "the relationship between a successful democracy and the children who form an integral part of that Democracy." The name "Conference on Children in a Democracy" was selected as being in harmony with this objective.

When the White House Conference on Children in a Democracy opened after 18 months of elaborate planning and $500,000 grant from private foundations, some 580 delegates representing various professions, official agencies, associations, and citizens groups attended. National and child health were among the topics considered by the Conference. It was reported to the Conference that despite the progress made in the 1930's there were still nearly 10,000 maternal deaths in 1938, of which many were preventable, 75,000 still births each year, and 70,000 deaths of infants and a considerable proportion of the still births were believed to be preventable. In light of these facts, the White House Conference adopted a strong program looking forward to an expansion of maternal and child health services.

Special emphasis was placed on the care of mothers and new born babies. It was held that every mother and child should get hospital care and the advice of specialists, if required. In addition, preventive
and curative medical care should be made available for all infants and children. These services, financed privately or publicly, were to include: (1) health supervision and care of infant and children, (2) health instruction in schools and health education for parents, (3) more intensive programs of safety education, (4) better advice on food and food preparation, (5) mental health service when needed, (6) medical care for sick children at home, clinic, or offices of qualified physicians, (7) hospital care, as necessary in approved hospitals with special facilities for children.\(^\text{82}\)

The White House Conference on Children in a Democracy suggested that the local community provide maternity care and health services for children and that the individual states provide leadership, financial assistance, specialized service, and supervise the development of local services. The Conference also proposed that the federal government assist the states through financial support, research, and consultation service and be responsible for setting standards of care and service on a nationwide basis.\(^\text{83}\) Federal grants were to be made available to the states for the development of maternal and child health services so as to reduce the existing inequality in medical care.\(^\text{84}\) It was recommended that the President appoint a national nutrition committee to coordinate the various efforts being made to improve the American diet.\(^\text{85}\)

In its "Call to Action," the White House Conference proposed a long-range program for carrying out its recommendations. By January, 1943, follow-up activities had been initiated by 26 states and the recommendations of the Conference had been given nationwide publicity.
in many professional publications and through the programs of national and local organizations.86

During the years 1936-1940, the Children's Bureau concentrated on building the child health program under the Social Security Act. Much of the Bureau's staff time and effort was given to the development of standards and policies for the administration of the state programs. In getting these programs underway, the Bureau characteristically turned to advisory groups, special committees, and state health departments for special guidance. Dr. Eliot and her staff promoted the concept of treating the whole child rather than a specific disability and of supplying professional care.

At the end of the first full year after funds were made available by Congress all states had maternal and child health programs underway. As the programs progressed, state agencies gradually developed and expanded the health service programs including medical, dental, nursing, and nutrition services for mothers, infants, preschool and school children. These services were almost entirely of the "Preventive" type. They included prenatal and postpartum clinics for maternity patients, infant and preschool child health conferences, health examinations of school children, immunization of children for diphtheria and smallpox, dental inspections, public health nursing services in the clinics, and nursing supervision of midwives.

By 1937, 39 states had approved plans for providing full services to crippled children. During the early years, the states concentrated on providing services for children with orthopedic handicaps,
but as additional funds became available, states began interpreting "crippled conditions" more broadly. By 1939 several states, encouraged by federal funds for "demonstration projects," began to set up special programs for children with rheumatic fever, rheumatic heart disease, and hearing impairment.

At first the maternal and child health programs were devoted to pre- and postnatal clinics and child health clinics and to training of professional personnel. In 1938, the Conference on Better Care for Mothers and Children recommended that the program be enlarged to provide medical and hospital care of mothers during labor and delivery.

All these activities contributed to a dramatic fall in death rates of mothers and infants which continued uninterrupted into the early 1950s. Although it is not possible to ascribe the sharp decrease in deaths solely to the services under Title V, these programs played a crucial part in saving the lives of many mothers and infants.

This effort to move ahead toward a more comprehensive medical care program for mothers and children came at a time when New Deal liberals were sponsoring a series of health insurance bills in Congress. The first, which aroused a great deal of interest, was introduced by Senator Robert Wagner of New York. The Wagner bill, S. 1620, which was based upon the recommendations of the Interdepartmental Committee to Coordinate Health and Welfare, proposed a comprehensive health insurance system for the general public, including expansion of state maternal and child health and crippled children programs. In late 1938, Dr. Eliot and Miss Lenroot let it be known that they had serious reservations regarding the compulsory health insurance; nevertheless the
Bureau officially endorsed the bill at the congressional hearings.

Despite an intense campaign against the Wagner bill by the AMA, the Congress approved in the next year an amendment to the Social Security Act authorizing an additional appropriation of $1,000,000 for handicapped children, with the understanding that it would be used, in part, in developing programs for care of children with rheumatic heart disease. In adding provision for care of children with a chronic illness to a program previously concentrated on children with physical handicaps, a step was taken toward a broadly inclusive medical care program for children. At the same time, funds for maternal and child health services were increased and requirements for a merit system were included in parts 1 and 2 of Title V. The Children's Bureau seemed quite satisfied when these amendments passed Congress in July, 1939 and provided the Bureau with most of the funds it had wanted from the Wagner bill.

Services in the field of maternal and child health were far from adequate although considerable progress had been made. The differential infant and maternal mortality rates in different states and the disparity between rural and urban rates and white and blacks were significant.\textsuperscript{87} It was estimated by Dr. Eliot that in 1941 when more than 7,000 mothers died in child birth, 50 percent of the maternal deaths might have been prevented if proper care had been supplied throughout pregnancy. Dr. Eliot estimated that the infant mortality rate could be reduced at least 25 percent and possibly as much as 50 percent if available knowledge were fully utilized. Another problem was the uneven distribution of health facilities.\textsuperscript{88} In a study of 654
cities in 1940 it was found that 46 percent had no outpatient clinics and 13 percent no hospital services for sick children. Furthermore, pediatricians were poorly distributed in small cities and rural areas and other medical facilities were unable to meet even minimum requirements. 89

Finally, the Children's Bureau sponsored and organized the White House Conference on Children in a Democracy. This fourth White House Conference focused attention on problems of nutrition, urged a national program of maternity care by 1950, and pressed for a more comprehensive crippled children's program.
The experience of the Children's Bureau with advisory committees dates to 1919 when the Pediatric Advisory Committee was appointed to advise on publications dealing with child care. It comprised four pediatricians who were appointed, one each, by the following organizations: American Academy of Pediatrics; Pediatric Section, American Medical Association; American Pediatric Association; and American Child Health Association. A second committee, the Obstetric Advisory Committee was appointed in 1926 to advise on publications dealing with maternal care. The Committee included only two members, both appointed by the Chief of the Bureau. Each of these committees was concerned with matters of a technical nature.

This Committee was composed of Dr. Fred L. Adair, University of Chicago School of Medicine; Hazel Corbin, R.N., New York Maternity Center Association; Robert L. DeNormandie, Boston; George W. Kosmak, editor of the American Journal of Obstetrics and Gynecology; James R. McCord, Emory University School of Medicine; Lyle G. McNeile, University of Southern California School of Medicine; Alice N. Pickett, University of Louisville School of Medicine; E. D. Plass, State University of Iowa College of Medicine; and Philip F. Williams, University of Pennsylvania School of Medicine. Lyle G. McNeile, "Maternal and Child Welfare; It's Progress Under the Social Security Act," California and Western Medicine, XXXXVII (1938), 241.


Report adopted by the Committee on December 17, 19735, CBP, NR, RG 102, Box 57, p. 1.


Report adopted by the Advisory Committee on Crippled Children on December 16, 1935, Records of the CBP, NR, RG 102, Box 57, p. 2.

Ibid., pp. 2-3.

Earlier, because of the failure of the third deficiency bill to become law before the adjournment of Congress, funds to carry out the provisions of the Social Security Act had not been made available.


Ibid.

Ibid., pp. 5-7.

Ibid., p. 6.

Ibid., pp. 7-8.


Ibid., 251.

At the end of the fiscal year 1937-1938, the crippled children program was administered in 24 states by the state department of health; in 15 by the department of welfare; in 5 by a crippled children commission; in 4 by the department of education; in 1 by a university hospital; and in 1 by an interdepartmental committee; ibid.

During the fiscal year 1937-1938 plans were approved for 5 additional states—Arkansas, Connecticut, Delaware, Nevada, and Oregon—
bring the total to 50 the number of jurisdictions receiving federal funds under the Social Security Act for services to crippled children; Director of Crippled Children's Division of the Children's Bureau, "Annual Report, 1937, The Child, II (1937), 37.

24Ross, Social Security Activities.

25Ibid.


29Ibid., 10-11.

30Ibid.


34Ibid., p. 3.

35Ibid.


37Ibid., p. 3.

38Children's Bureau, Proceedings, pp. 22-23.
A meeting of the "Continuing Committee" was called in Washington on March 12, and the representatives of 61 organizations formed themselves into a permanent National Committee on Better Care for Mothers (later changed to National Maternal and Child Health Council). The object of the Council was to exchange information, to furnish material for study, to analyze proposals and "other wise to assist in the effort to increase interest in better care for mothers and babies;" U.S. Interdepartmental Committee to Coordinate Health and Welfare Activities, Report of the National Health Conference, July 18, 19, 20, 1938 (Washington, D.C., 1938), p. 5; "Can Motherhood be Made Safe?" Public Health Nursing, XXX (1938), 269-270; Elizabeth Morrison Wagenet, "Better Care for Mothers and Babies: The National Maternal and Child Health Council Offers Constructive Leadership," Journal of the American Association of University Women, XXXIV (1941), 161-163.


General findings of the survey with respect to the occurrence of disease, accidents, and impairments are reported in "The National Health Survey; Some General Findings," by R. H. Britten, S. D. Collins, and J. S. Fitzgerald, Public Health Reports, LV (1940), 444-470.

Earlier important surveys include a series of canvasses in South Carolina cotton-mill villages by the U.S. Public Health Service, 1916-1918; its Hagerstown studies, 1921-1924; surveys of 9,000 families in 130 communities by the Committee on the Costs of Medical Care, 1928-1931; and the Health and Depression Studies of the U.S. Public Health Service, 1933, among 11,500 wage earners' families in 8 large cities and two groups of coal mining and cotton-mill villages; U.S. Public Health Service, National Health Survey, pp. 1-2.

Interdepartmental Committee to Coordinate Health and Welfare Activities, A National Health Program (Washington, D.C., 1939).

Ibid., p. 1.

Ibid., pp. 1-3.

Ibid., pp. 1-4.

Ibid., p. 37.

Ibid.

Ibid., p. 3.


54 Interdepartmental Committee to Coordinate Health and Welfare Activities, Report and Recommendations on National Health (Washington, D.C., 1939); this report may be found in U.S. Congress, Senate, Hearings on S. 1620, 76 Cong., 1 Sess. (1939), pp. 19-33.

55 Ibid., pp. 30-33.


57 S. 1620, 76 Cong., 1 Sess. (1939).


59 Memorandum from Dr. Eliot to Miss Lenroot, November 12, 1938, Records of the Children's Bureau, National Archives, Record Group 245, Box 24. Hereafter the Records of the Children's Bureau is indicated by the symbol RCB, followed by National Archives NA and the group number RG.

60 Letter from Miss Lenroot to Senator Elbert D. Thomas, March 10, 1939, RCB, NA, RG 245, Box 24.

61 Hearings on S. 1620.

62 Ibid., pp. 17-19.


Review," Social Security Bulletin, II (1939), 1. In May, 1937, the President created an Advisory Council on Social Security to facilitate Revision of the Act. The Council spent more than a year in study and deliberation and transmitted its final report and recommendations on December 19, 1938 to the President.

68 Ibid.


70 U.S. Congress, House, House Document No. 120, 76 Cong., 1 Sess. (1939).

71 S. 1620, 76 Cong., 1 Sess. (1939).

72 Hearings on S. 1620.


74 Ibid., pp. 31-32.


76 Under the 1935 Act annual federal grants to states were not to exceed a total of $3,800,000 for maternal and child health services and $2,850,000 for services for crippled children.

77 Mary Ross, Special Children's Programs (unpublished report) CBP, NR, RG 363, Box 57.

78 Katharine F. Lenroot, What the Children's Bureau is Doing about Heart Disease (unpublished speech given at the San Francisco Heart Committee on November 10, 1942), CBP, NR, RG 363, Box 157, pp. 1-3.

79 Two separate Senate bills (S. 3235 and S. 3370) to establish a merit system were introduced by Senator Mckellar and Senator Byrnes in 1938. The Bureau endorsed both proposals; see U.S. Congress, Senate, S. Resolution 226, S. 3235, and S. 3370, 75 Cong., 3 Sess. (1938), pp. 2-3, 16-17, 28-30.

80 U.S. Children's Bureau, Recommended Standard for the Establishment and Maintenance of a Merit System of Personnel Administration and for Qualifications of Certain Classes of Professional Employees in State and Local Agencies Administering Maternal and Child Health Services, Services for Crippled Children, or Child Welfare Services (Mimeograph, November 1, 1939), CBP, NR, RG 363, Box 145.

82Ibid., pp. 285-87.
84Ibid., pp. 18-20.
85Ibid., p. 18.
89Hearings on S. Resolution 74, p. 1861.
CHAPTER IV

FEDERAL CHILD HEALTH SERVICES IN
WARTIME, 1942-1945

During World War II the Children's Bureau had to modify its programs to meet the impact of the war emergency on child health. Because of a shortage of federal funds and trained medical personnel, the Bureau was forced to restrict the expansion of the maternal and child health program. There was a corresponding decrease in state maternal and child health and crippled children services under the Social Security Act, beginning in 1942 and 1943. Health services were unavailable to children in many counties and small cities. At the same time, the Bureau launched an innovative new program--known as the Emergency Maternal and Infant Care Program--for the wives and babies of servicemen. With the help of Senator Claude Pepper the Bureau actively campaigned for a more comprehensive maternal and child health program.

With the beginning of the war and subsequent loss of professional personnel to the armed forces, the states were forced to curtail maternal and child health services. The total volume of services rose slightly during the first year of the war and then, starting in 1943, began to show decreases. Reports from the states for 1943 indicated that under state health department supervision 146,000 women were given antepartum medical service, a decrease of 12 percent from the high
point in 1942. The number of infants admitted to child health conferences for medical services was 186,000, approximately the same number as in each of the preceding two years. Public health nurses in 1943 made 1,227,000 antepartum and postpartum visits, a decrease of 8 percent from the number made in 1942, which represented the peak of such services; nurses made 4,844,000 visits for infant, pre-school, and school hygiene, a decrease of 8 percent from 1942. The number of examinations of school children in 1943 by physicians reported was 2,124,000 which showed an increase of 30.8 percent over the highest numbers reported in 1942.2

By 1945, medical services fell to levels below that of 1940. The number of children admitted to child health conferences was only 170,000 in that year, a decrease of 6 percent over the 1943 figure. Reports from state health agencies showed that 1,224,000 prenatal and postnatal public health nursing visits were made in 1945, approximately the same as the two preceding years. In 1945, physicians made 1,117,000 medical examinations of school children, a decrease of 50 percent over the 1943 figure.3 Immunization against smallpox and diphtheria followed the downward trend. States made efforts to replace key personnel as they left, when possible, and through re-organization of maternal and child health programs, to enable the limited personnel, remaining to serve larger numbers of mothers and children.

(Despite the disruptions caused by the war, steady progress was made in the 1942-1945 period in reducing the maternal and infant mortality rates. The maternal mortality rate for the year 1945, 20.7 deaths per 10,000 live births, was the lowest ever recorded in this
country prior to that time—a decrease from 37.6 in 1940. Likewise, the infant mortality rate declined from 47.0 deaths per 1,000 live births in the period from 1940 to 38.3 in 1945. During the same time period deaths from scarlet fever and streptococila infections showed a striking decline. In fact, scarlet fever reached such a low mortality rate that it was no longer considered a serious menace to children.4)

The war also reduced the number of crippled children who received hospital and convalescent-home care. Spiraling costs, the withdrawal of hundreds of surgeons, nurses, and physical therapists for service in the armed forces, shortage in hospital facilities and services, and restrictions on the manufacture of metal appliances contributed to the decline of state crippled children programs.5

The annual state reports submitted to the Children's Bureau showed that the number of crippled children reached by state crippled children programs increased from 1937 up to 1942; and then declined until the end of the war. In 1943 state health agencies reported to the Children's Bureau that there were over 5,000 crippled children on state registers who did not receive medical attention. The number of crippled children admitted to clinic service in 1943 (82,000) was 11 percent less than in 1942 and 21 percent less than in 1941. The 31,000 crippled children cared for in hospitals during 1943 was 13 percent less than in 1942 and 27 percent less than in 1941. A similar decline was evident in convalescent home care, in physical therapy, in public health nursing, and in medical social services.6 The volume of services to crippled children continued to decline in 1944 and in 1945. For example, Tennessee reported to the Bureau that in 1944 more than
100 children with cleft palates could not be provided with medical care because of the non-availability of plastic surgeons. Other such examples could be cited.

Fewer crippled children received care in clinics, hospitals, and convalescent or foster homes, and public health nursing and physical therapy services declined. For example, approximately 373,000 crippled children were listed on state registers in 1944, 19,000 above the figure for the previous year. Yet the volume of services for crippled children under the federal program continued to diminish primarily as a result of insufficient funds, lack of professional personnel, and over-crowding of hospitals. The number of children admitted to clinic services during the first six months of 1944 was 9,080 less than in the corresponding period of 1944, a reduction of 14 percent, and the number of crippled children receiving hospital care showed an even larger percentage reduction, 28 percent. Services provided by public health nurses and physiotherapists declined. By 1945, the Bureau estimated that the federal grant-in-aid program assisted less than 10 percent of the handicapped children of the nation. The return of medical personnel from the war in 1945-1946 resulted in a rapid increase in the services provided crippled children.

Furthermore, under a general federal policy, research programs that could not be justified as contributing to the war effort were dropped. This policy curtailed the Bureau's research program. Nevertheless, in relation to its wartime program of maternity and infant care for wives and infants of servicemen (known as The Emergency Maternity and Infant Care Program), the Bureau between 1941 and 1943
studied conditions around military camps to determine the medical facilities available to the wives of servicemen. Later the Bureau undertook an extensive study of neonatal deaths. The results of this study which showed that 62 percent of all infant deaths in 1944 occurred when the infant was less than a month old brought to national attention the importance of concentrating efforts on the care of premature infants.9

On June 17, 1940, the National Citizens Committee urged the importance of the maintenance and extension of health services and medical care for all, particularly mothers and children. President Roosevelt gave official recognition to the importance of child and maternal health in the National Defense Program—notably in the Executive Order of November 28, designating the Federal Security Administrator as Coordinator of health, medical, welfare, nutrition, recreation, other related fields of activity affecting the national defense. One of the objectives of the Office of the Coordinator as stated in the first general bulletin was the following: "To promote the health, security, and morale of the civilian population as an essential part of effective defense."10

The relation of maternal and child-health to national defense was three fold:

(1) The immediate relation of the health of their wives and children to the morale of men in the service and engaged in industrial production;
(2) Prevention of the economic and social waste involved in caring for preventable illness; and
(3) The building of a strong and healthy generation of citizens prepared to cherish and extend a way of life based upon the principles of freedom.11
The State and Territorial Health Officers in Conference with the Children's Bureau in April, 1941 and again in 1942 proposed substantial increases in federal aid for maternal and child-health services. This was to provide for the continuing expansion and improvement of state maternal and child-health services throughout the nation, including medical examination and correction of remediable defects of school children.\(^\text{12}\) The National Council of State Public Assistance and Welfare Administration in December 1940 and again in 1941, and the American Youth Commission in January 1940, made similar recommendations for improving public health.\(^\text{13}\) To consider the effects of the war on children, a Children's Bureau Commission on Children in Wartime was appointed and met for the first time in March 1942, under the chairmanship of Leonard W. Mayo, President of the Child Welfare League of America. The Commission membership included the chairmen of the Advisory Committees of the Children's Bureau, representatives of national organizations concerned with the welfare of children, and state officials from health and welfare agencies directly responsible for administering programs for children.

The National Commission on Children in Wartime adopted a charter on March 18, 1942, which outlined four key objectives of a wartime health program: (1) guard children from injury in danger zones; (2) protect children from neglect, exploitation, and undue strain in defense areas; (3) strengthen the home life of children whose parents are mobilized for war or war protection; and (4) conserve, equip, and free children of every race and creed to take their place in a democracy.\(^\text{14}\)
In specific resolutions the National Commission on Children in Wartime called for additional federal funds to supplement state funds and for the early establishment in every county of public health nursing service, prenatal clinics, delivery care and child health conferences. It was also recommended that state and local planning bodies for children and youth encourage the development of constructive programs of action to promote the health of mothers and children in defense areas.

On March 17-18, 1944, the Children's Bureau Commission on Children in Wartime adopted "Goals for Children and Youth as We Move from War to Peace." After more than two years of war, the National Commission on Children in Wartime recommended an extension of health services and medical care to all mothers and children. Specifically, the National Commission proposed the following:

1. Provision of health services for infants and young children through the organization of well-child health centers in every community lacking such facilities, and extension of such service when it is inadequate.

2. Development of adequate health and medical care programs, including health education, for school children and employed youth with extension of school lunch and nutrition programs, and enlargement of the crippled children program to include particularly service for children with rheumatic fever and cardiac conditions in all states.

3. Making available public care or health insurance programs as needed to assure access to adequate care for all mothers and children.

4. Planning for demobilization of medical and nursing personnel in the armed forces.

A special committee of the National Commission on Children in Wartime spent a year surveying the needs of American children and youth. In April, 1945, the Commission issued its report and recommendations in a pamphlet entitled "Building the Future for Children and Youth."
this report the National Commission on Children in Wartime outlined a plan for increasing health services for mothers and children over a 10 year period so that at the end of that time health services would be available to all children. It was held that these goals could be achieved by greatly enlarging and expanding the services offered children since 1935 by the Social Security Act. To accomplish this the report urged that the federal government greatly increase its expenditures for maternal and child care.

The National Commission suggested that in the first year of expanded services the Congress appropriate $50,000,000 for maternal and child health care—$25,000,000 for maternity care and care of infants and preschool children; $15,000,000 for preventive and curative health services for school children; $10,000,000 for dental care of young children. For crippled children's services the Commission recommended that federal funds available for grants to states be increased by $25,000,000--$5,000,000 to expand the program for orthopedically crippled children and to start a program for children with cerebral palsy; $5,000,000 for other physically handicapping conditions, including defects of vision, hearing; and $15,000,000 to expand the program for children with rheumatic fever and rheumatic heart disease. 18

With these funds the National Commission on Children in Wartime believed that special emphasis should be placed on adequate care for mothers and newborn babies, expanded school health services, including a dental-care program, creation of mental health programs for children and new services for physically handicapped children. 19 The Commission recommended that the various states assure the availability of services
without discrimination. If the states could not or would not do this with regard to race, color, creed, national origin, and without regard to residence requirements then they should not be granted funds for maternal and child health services.20

The Commission held its final meeting February 5-7, 1946, at the Children's Bureau and recommended the appointment of a National Commission on Children and Youth. A plan setting up the new Commission was outlined; and in October, 1946, the National Commission on Children and Youth was officially organized under the leadership of Leonard Mayo, President of the Child Welfare League of America. Approximately 50 national organizations including farm labor and citizens groups, were included in a membership of a little more than 100.21 The purpose of the new commission was defined as follows:

To raise the levels of health education, and welfare of the Children of the Nation so that they may have full opportunity to develop their potentialities and to become responsible and cooperative members of society.

To this end, to arouse all citizens to cooperative action in support of the public and private services needed to realize this objective for all citizens and youth throughout the United States.22

The interim report of the United States Subcommittee on Wartime Health and Education, known as the Pepper Committee, confirmed dramatically the findings of the National Commission. The Subcommittee on Wartime Health, with Senator Claude Pepper of Florida as chairman, was created by the Senate in 1943 to investigate the large number of young men found unfit for military service.23 At the hearings of the Subcommittee Major General Lewis B. Hershey, Director of the Selective Service System, testified that 4,500,000 men were rejected by the military because of physical and mental defects. In addition to this,
General Hershey stated, more than a million men were discharged from the army and navy because of physical defects other than those sustained in battle, and approximately 1,500,000 men with major defects were rendered fit for service, including a million men with major dental defects, more than 250,000 with impaired vision, 100,000 with syphilis, and more than 7,000 with hernia. Thus an estimated 40 percent of the 22,000,000 men of military age were found to be unfit for military duty. Officials of the Selective Service System estimated that at least one-sixth of all the 4F's had defects which could have been remedied with relative ease during childhood.24

The congressional witnesses emphasized the necessity of correcting physical defects early in a child's life. This was illustrated by a U.S. Public Health Service survey of Hagerstown, Maryland. The health of the school children of Hagerstown was observed over a 15 year period; then the Selective Service medical records of the Hagerstown registrants were compared with the school health records of the same individuals during childhood. The comparison showed that most of the defects for which registrants were rejected had been discovered in high school and grade school and were not corrected during the intervening years.25

Based on the preliminary findings, the Pepper Committee issued, in its 1945 Report, detailed recommendations concerning the need for improved preventive medical services and facilities.26 The Subcommittee proposed federal grants-in-aid to states to assist in post-war construction of hospitals, medical centers, and health centers; federal scholarships to qualified students desiring medical and dental
education; increased federal grants to states for maternal and child health care. The most far reaching suggestion was for improvement of child school health programs to insure the adequate treatment of children with physical defects.

Senator Pepper used many of the recommendations of the Subcommittee and the National Commission on Children and Youth in the bill (S. 1638) which he introduced in the Senate on July 26, 1945. Joining Senator Pepper in sponsoring S. 1318 were Senator Walsh of Massachusetts; Senator Thomas of Utah; Senator Hill of Alabama; Senator Chavez of New Mexico; Senator Tunnell of Delaware; Senator Guffey of Pennsylvania; Senator LaFollette of Wisconsin; Senator Aiken of Vermont; and Senator Morse of Oregon. The bill was referred to the Senate Committee on Education and Labor, of which Senator Murray of Montana was chairman.27

The bill was designed to enable the states over a 10 year period to make adequate provision for the health and welfare of mothers and children during the maternity period. This bill included medical nursing, dental, hospital, and related services plus facilities required for maternity care, preventive health work and diagnostic services for children, school health services, care of sick children and correction of defects. To achieve the stated objectives, the bill proposed an appropriation of $100,000,000 for the fiscal year ending June 30, 1946. Of this amount $50,000,000 was earmarked for maternal and child health services, $25,000,000 for services to crippled children, $20,000,000 for child welfare services, and $5,000,000 for expenses necessary to enable the Children's Bureau to administer the provisions of the bill. The Children's Bureau was also to develop effective measures for
carrying out its purposes, including studies, demonstrations, investigations and research, the training of personnel for federal, state, and local service. The Bureau's $5,000,000 appropriation also went for the payment of salaries and expenses of personnel detailed at the request of state agencies to cooperate with and assist such agencies in carrying out the objectives of the legislation.28

Of the total appropriation, $15,000,000 would be matched dollar for dollar on the basis of proportional child population. The remainder would be allocated on the basis of local medical care costs, special maternal and child health problems, and the financial need of the state for assistance in carrying out its program. The bill provided that states would pledge themselves to extend the program each year until it became state wide. States were also required to agree not to permit race discrimination and to assure competent administration.

Several of the proposals of the National Commission on Children in Wartime were also embodied in the Wagner-Murray-Dingell bill (S. 1606) outlining a national health insurance program which was introduced in the Senate on November 19, 1945.

The Bureau's Advisory Committee on Services for Crippled Children, at its meeting in December, 1944, recommended that the administration of all medical care programs and health services, including services for handicapped children, should be placed under a single overall health agency. In April, 1945, the Maternal and Child Health Committee of the Association of State and Territorial Health Officers urged that laws be revised in those states where the crippled children's agency was a department other than a state health department to provide
for a transfer of crippled children's services to the state health department. The National Commission on Children in Wartime, in its 1945 report, suggested that crippled children services by the state health agency be a condition of approval for a state plan submitted in requesting federal funds for this purpose. The Children's Bureau requested all states to transfer administrative authority to the state department of health. By 1946, services for crippled children were administered in 31 states and territories by state departments of health.

During the war years the Children's Bureau actively undertook to develop medical services for crippled children with rheumatic fever. By 1944, 19 state programs had been initiated; however, only 240 counties out of 3,050 counties in the United States were covered by these programs. Work in this area was stimulated by a National Conference on Rheumatic Fever called by the Children's Bureau on October, 1943, at which state and federal agencies and professional and lay national voluntary agencies and associations participated.

Early in World War II, difficulties in providing obstetric and pediatric care to the families of servicemen led to establishment by the Children's Bureau of the Emergency Maternity and Infant Care Program, popularly known as EMIC. The following year, plans for the operation of EMIC programs were approved by the Bureau for 48 states, the District of Columbia, Alaska, Hawaii, and Puerto Rico. The program continued until July 1, 1949, with total expenditures of $108,000,000 for 1,169,000 maternity patients and $14,000,000 for 217,000 sick infants. Eligibility for the program was limited to the four lowest
pay grades in the military services, upon application by the wife of
the serviceman. Payment was provided for medical, hospital, nursing,
and other types of maternity care.

During late 1940 and early 1941 there was increasing evidence
that maternal and child health needs were not being met in the defense
areas of the United States. The rapid growth of more than 400 defense
areas where expansion of war industries and establishment of military
camps had resulted in an increase in the number of women and children
put a strain on existing health services. Provisions for maternity
and infant care were utterly inadequate in many of these defense areas.
Some of the areas had not previously provided maternal and child-health
services. The withdrawal of physicians for the armed services meant
that women had to rely heavily upon untrained midwives. The acute
shortage of maternity beds was so great that some hospitals were dis-
charging women 24 hours after delivery. Other hospitals were discharg-
ing patients on the third, fourth, or fifth day, with no assurance that
public health nurses would be able to visit them. The congestion in
the hospitals resulted in dangerous crowding in the nurseries for new-
born infants as well as in maternity wards. Epidemics of infectious
diarrhea were reported by hospitals with high death rates, sometimes as
high as a third or half of the cases. In some areas, hospital care
for sick children was wholly unattainable.

In the summer of 1942, 32 state health officers reported unmet
maternity and child-health needs in 366 defense areas. Funds had not
been available to purchase equipment or prenatal and child-health
conferences nor to pay personnel to conduct these conferences and to
maintain the other medical, dental, nursery, and nutrition services.
In October, 1942, of the 33 State health officers replying to a ques-
tionnaire, 22 reported a shortage of practicing physicians and nurses.
Nine states indicated the need for 800 physicians and 23 states a
shortage of 200 health officers. 37

The first state program for care of wives of servicemen took
shape in the State of Washington in 1941 as one of the maternity care
projects under the maternal and child health program of the State Health
Department. In February, 1941, the Commandant at Fort Lewis requested
the Washington State Health Department to assist in obtaining maternity
care for the wives of enlisted men at the camp. 38 The Division of
Maternal and Child Health had approximately $14,000 of unexpended funds
from the B Fund, which was outright federal grants to the state on the
basis of need. In March, 1941, the Division asked the Children's
Bureau for permission to use this fund for the purpose of providing
obstetrical and hospital services for the wives of servicemen and
approval was granted. From August, 1941, until July, 1942, 677
maternity cases had been enrolled, 193 women had been delivered and 432
were receiving prenatal care. 39 This maternity care project in the
Pacific Northwest was designated a "demonstration" by the Children's
Bureau. Title V of the Social Security Act permitted the Bureau to
finance special demonstration projects with federal funds.

By July 1, 1942, 27 additional states had received permission
to use B Funds to provide maternity, obstetrical, hospital, and pedia-
tric care for the wives and infants of servicemen. The Children's
Bureau allotted $390,177 for these services during the year. By
December 1, 1942, 37 state health departments had requested funds, totaling $544,000 for emergency care but money available under the B Fund had been exhausted.\(^4\)

On March 27, 1942, the Committee on Maternal and Child-Health of the Association of State and Territorial Health Officers recommended that state health agencies develop plans to finance from maternal and child health funds the medical and hospital care needed by wives and children of men in military service unable to purchase medical care. This Committee also recommended that medical and nursing service be made available for mothers and children in critical areas.\(^4\)

At the time the first projects were initiated the problem of providing care for wives and infants of servicemen was becoming acute in many areas, especially near military bases.\(^4\) Many of the wives were non-residents and therefore not eligible for community services. Private funds proved to be insufficient to meet the need for medical and hospital care of military dependents. The Army was forced to discontinue, in many areas, medical and hospital care for wives of servicemen which it usually provided during peacetime.\(^4\)

Red Cross representatives at 240 Army posts reported to the Children's Bureau that during one month in the summer of 1942, 3,262 soldiers requested help in securing maternity care for their wives; 39 percent of these requests were for assistance in obtaining care for wives living near army posts, 61 percent were for care of wives living in another state.\(^4\) In August, 1942, the American Red Cross received reports from a 10 percent cross section of its chapters in 46 states that 2,601 soldiers or sailors wives had requested assistance in
obtaining maternity care or care for sick children. Correspondence with public health nurses, Red Cross workers, and state health officials confirmed the growing need. A Red Cross worker in California wrote the Bureau:

I have recently received a communication from the Pacific Area of the Red Cross in San Francisco to the effect that the Children's Bureau was concerned about maternity care for the wives of soldiers. It so happens that within the past two weeks the situation has grown out of bounds due to the increased Army population and also to the fact that this is the time when we might rightfully expect an increase in babies. The Army hospital has taken these women for prenatal care and for delivery until two weeks ago, when this service had to be discontinued. This left about 50 expectant mothers with no arrangements for prenatal or maternity care.

A public health nurse in New Mexico informed the Bureau of the urgency of the situation:

A large problem is being created when men are being called to the army leaving pregnant wives to make their own arrangements for care during their confinement. At the present time the welfare department has no funds to handle this case load. We are able to encourage these mothers to attend our prenatal clinics for medical supervision but are at a loss when plans for confinement must be made. One keeps in mind constantly our high infant and maternal death rates and feels that we are meeting the problems only half way.

The first six months experience under the approved state health department plans demonstrated a great and growing need. Because of limited funds, the states had not been able to accept all applications for care. One state, for example, which started its program in August, 1942, had accepted 305 applications in two months, completely exhausting all available funds. The Missouri State Board of Health wrote to the Children's Bureau on November 25, 1942, that dozens of requests for services were being received by the health department from soldiers' wives and that their funds were exhausted. In North Carolina the health
department originally estimated that $5,000 to $10,000 would be sufficient to provide the necessary services. Two months after the program was started they requested $200,000 additional to maintain the services for the remaining seven months of the fiscal year.48 By mid-December, 1942, 27 states with approved plans reported 3,409 applications for maternity care had exhausted their funds.49 Estimates received from the state health departments for the first half of 1943 indicated that maternity care would be needed by approximately 25,000 women and infants of enlisted men. By 1943, the Children's Bureau completely exhausted the funds to the point where it was necessary to ask Congress for an additional appropriation.50

To meet part of this need the Children's Bureau asked for a supplementary appropriation of $1,817,200 to carry forward existing programs until June 30, 1943. The request was referred to the Committee on Appropriations of the House of Representatives on February 3, and it became part of the First Deficiency Appropriation Bill of 1943 (H.R. 1975).51 Miss Lenroot and Dr. Eliot appeared before both the House Subcommittee of the Committee on Appropriations and the Senate Subcommittee on Appropriations to justify their request for additional funds. Concerning the need, Miss Lenroot testified as follows:

Experience during the past 5 months shows that the demand for this service is very great, the sums available have not been sufficient to enable some states to accept all the cases for which application has been made.52

At the House hearings, the members of the Subcommittee did not question the need for additional funds since the discussion turned to the details of administration. Miss Lenroot explained that the states would not be expected to provide funds. The Chairman of the
Subcommittee, Representative Hare of South Carolina, expressed concern as to whether or not it was a continuation of an already established program or a totally new one: "This then is not initiating a new program or starting a new project. It is going on at the present time. The proposition before us is not to provide a new activity but to continue your present activity." Miss Lenroot answered: "Yes." 53

Despite this assurance, the House Subcommittee in House Report No. 170 on February 24, 1943, rejected the Children's Bureau's request stating that enabling legislation should be enacted for such a program. The report said: "The funds requested are not predicated upon any existing law but are left entirely to the discretion of the Secretary of Labor and the Chief of the Children's Bureau." 54

On March 2, 1943, the Senate Subcommittee restored the Children's Bureau's appropriation to the First Deficiency Appropriation bill. The members of the Subcommittee were concerned with the same issue as the House Subcommittee, namely, whether or not it was a new program. Miss Lenroot and Dr. Eliot assured the Subcommittee as to the legality of the program. Miss Lenroot said that authority for the program existed in Title V, part 1 of the Social Security Act and she went on to report that 28 states had approved plans under which they were providing services to the wives of enlisted men. 55 Ten of these states had exhausted their funds and in a number of other states the funds would be shortly exhausted.

In March after full discussion with representatives of the Children's Bureau and publication of the testimony at the hearings, Congress passed and the President signed the First Deficiency
Appropriation bill for 1943. The Emergency Maternity and Infant Care Program (EMIC) which had begun as an expansion of Title V of the Social Security Act now had the tacit approval of Congress. By June 30, 1943, 43 states had approved EMIC plans in operation. On March 24, 1943, less than a week after EMIC became law the Children's Bureau expressed a need for $6,000,000 to cover the program for the next fiscal year, July 1943 through June 1944. By the time it reached the House Committee on Appropriation, the amount had been reduced to $4,400,000. During the hearing on the bill the Chairman of the Subcommittee raised the desirability of a means test. He was concerned about its omission in the original act, but Miss Lenroot resolved the problem to his satisfaction in her testimony before the Committee. This apparently settled the issue because it was not discussed by the members of the Committee again.

When the appropriation bill reached the Senate, chief attention was paid to whether the Children's Bureau should have the power to determine standards for a practitioner participating in the EMIC program. The majority opinion was in favor of state determination of standards; the House concurred with this view and on July 12, 1943, H.R. 2935 was signed by the President becoming Public Law 135.

By the middle of August, 1943, the Children's Bureau realized that it had underestimated the demand for services. On August 25, the Bureau reported the need for a supplement of $20,076,235 with $622,799 to be allotted to states for the cost of administration. In his recommendation to the Committee on Appropriations of the House of Representatives on September 16, the President reduced the original
figure to $18,600,000 with nothing earmarked for administration. At
the House hearing Miss Lenroot stated: "The Children's Bureau had
greatly underestimated the number of cases which would require care
under the program. It was thought that 25 percent of the total antici-
pated deliveries would apply for assistance. The actual experience of
the first five months of fiscal year indicates that about 50 percent
of the eligible cases will apply for care." On September 22, the
House passed the bill which quickly received the approval of the Senate.
In October, President Roosevelt signed the First Supplemental National
Defense Appropriation Bill into law.

Congress, in appropriating these funds, made it clear that the
major purposes of the program were two-fold: (1) to provide all medi-
cal, nursing, and hospital care needed during the maternity period and
the infants first year of life; and (2) to relieve the enlisted men and
their wives of any anxiety concerning the cost of such care. From
the start, Congress regarded the EMIC program as a wartime measure to
which any wife or infant of an enlisted man in one of the four lowest
pay grades was entitled. No financial need test was established by
Congress, and Congress stated that there would be no discrimination or
residency restrictions.

The Children's Bureau established minimum standards and fiscal
controls that the Bureau would use in approving state EMIC plans. On
May 1, 1942, the Bureau drew up a formal set of policies which it sent
to the state health departments. The Bureau suggested that the plans
they requested for EMIC funds be submitted at the same time that the
regular annual maternal and child health plans were submitted. On
March 18, 1943, after the first EMIC appropriation act was passed by Congress, the Children's Bureau drew up another set of policies, MCH Information Circular No. 13, superseding all other memoranda in the first set of instructions. MCH Information Circular No. 13 presented in detail the information required of the state health departments before their plan would be approved. In December, 1943, the Bureau issued a new bulletin, "Administration Policies--Emergency Maternity and Infant Care Program" (EMIC Information Circular), which superseded Circular No. 13. After the publication of EMIC Circular No. 1, the Bureau made approximately 30 revisions of the regulations.

The states were required to indicate in their plans methods of application for care, policies of authorization for payment of services, referrals for medical services and social services, rates of payment for medical services and hospital care and all pertinent statistical and financial data. The Children's Bureau created requirements on all these items with which the state had to comply in order to receive federal funds. Since EMIC was an emergency program financed entirely by the federal government, the Bureau assumed a great deal of responsibility in the formulation of policy.

Circular No. 13 and EMIC Circular No. 1 presented in detail the information required of the state health departments before their plans could be approved. Benefits were to be in the form of services and not cash allowances to the wives of enlisted men, and to include complete medical, nursing, and surgical care for maternity patients throughout pregnancy, labor, and six weeks' postpartum, for major recurrent conditions during, but not attributable to, pregnancy, and for the care
of sick infants. Other miscellaneous services, such as blood transfusions, x-rays, laboratory and ambulance services, were to be provided as necessary and available. Although the rates of payment were fixed in the state plans for each kind of service, no limitation was placed on the amount or variety of service provided or upon the total paid for all kinds of services. No restrictions were made with respect to legal residence or in relation to race, color, and creed of the patient. The eligibility of the wife and infant to participate in the program was determined by the state agency, with the assistance of the wife's physician, before authorization for care was given. Once authorization was granted, the physician or hospital was assured of direct payment of the bills by the state agency from funds paid in advance to the state by the Children's Bureau.67

In addition, the Children's Bureau adopted standards to serve as guides for the designation of physicians and other personnel qualified to render service as well as for the approval of hospitals. State health agencies were responsible for inspection of hospitals and could set their own standards at or above the minimum required by the Bureau. Many hospitals had to make basic improvements before being accepted for participation in the program, such as adding separate facilities for the care of obstetrical patients, running water in the delivery room, and screening.68 The Bureau held that hospitals should be paid upon the basis of the "ward-cost-per-patient day." The same method for payment for hospital care had been used under the Crippled Children's Program of the Bureau.69

In developing the general policies established for the
administration of EMIC, the Children's Bureau sought the advice of the Conference of State and Territorial Health Officers and the Maternal and Child Health Committee of the Association of State and Territorial Health Officers. The Bureau also consulted with its special obstetrical and pediatric advisory committees, with various professional organizations, and with groups of hospital administrators.70

Immediately following the passage of the First Deficiency Bill for 1943, the Children's Bureau requested the Association of State and Territorial Health officers to hold a special meeting to discuss the EMIC program, but it was not possible for the officials of the Association to arrange such a conference. Twenty three of the state maternal and child health directors and state health officers, however, met with the staff of the Children's Bureau on March 24, 1943, during the week of the health officers' meeting in Washington and discussed in detail the problems of Administration related to EMIC.

During the regular meeting of the State and Territorial Health Officers with the Children's Bureau on March 25, 1943, the only questions concerning the Emergency Maternity and Infant Care program raised by the health officers were related to desirable qualifications and standards for participating physicians and hospitals. At a meeting of the Advisory Committee on Maternal and Child Health on April 6, 1943, all proposed policies of the Children's Bureau for the administration of the EMIC program were reviewed. As a result a number of modifications were made in the light of the opinion of the committee. At a meeting of the medical members of the Committee in October, policies were again reviewed and recommendations with respect to further modifications
made. After the Conference a memorandum was issued amending the policy in regard to physicians fee for sick infants. In the same memorandum it was suggested that the funds under the regular maternal and child health program could be used for the employment of medical social workers. Further refinement in the determination of hospital cost was required of state agencies administering the EMIC program.

The Nursing Advisory Committee of the Children's Bureau met on October 4, 1943 to discuss, among other subjects, the EMIC programs. A second meeting of the medical members of the Advisory Committee on Maternal and Child Health was held on October 21, 1943 to consider revised policies for the EMIC program. On the advice of the committee and in view of the participation of general practitioners in the EMIC program five additional members in private practice, three of whom were general practitioners, were appointed to the committee.

On December 10 and 11, 1943, in response to a resolution of the Executive Board of the American Academy of Pediatrics, the Children's Bureau held a Conference of official representatives of the various medical organizations rendering service under the program. This conference included representatives of the American Medical Association, the Academy of Pediatrics, the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, and the U.S. Public Health Service. In addition the Bureau included official representatives of the Association of State and Territorial Health Officers, American Red Cross, the Army Emergency Relief, the Navy Relief Society, American Legion, and five national citizens organizations. Forty-eight persons attended the Conference. At the Conference, administrative policies
were reviewed again in detail and subsequently were completely rewritten. Practically all of the formal recommendations of the Advisory Committee made in October and of the Conference in December were incorporated in EMIC Information Circular No. 1. Miss Lenroot emphasized the fact that it was no part of the purpose of the Children's Bureau to carry over the EMIC program into the post-war period. She stated, "I want to make it clear that this emergency maternity and infant care program was developed in response to need and was in no way a part of any master plan or strategy. It was developed very simply as a measure to meet war need as a result of the experience in the State of Washington and other places and of the evidence of need that was coming to us." Finally, the relation of the Children's Bureau policies to the intent of Congress as expressed in the Appropriation Acts and in hearings and debate was clarified at the Conference.76

On February 1 and 2, 1944, a conference of pediatricians, health officers, and maternal and child health directors was held at the Children's Bureau. The Bureau hoped to obtain a wider opinion on the problems of medical care of infants under the EMIC program and carry forward the discussion of the December convention. The responsibility of the pediatrician, the general practitioner, and the child health conference in providing health supervision and methods of financing were discussed in detail. During the war years, the Children's Bureau also held regional conferences to discuss with maternal and child health staffs problems related to the EMIC program.

A storm of criticism developed over the administration of the Emergency Maternal and Infant Care Act. Although representatives of
organized medicine endorsed EMIC as a wartime measure, they expressed the fear that the program jeopardized the sacred "doctor-patient relationship." The American Medical Association objected to the Children's Bureau setting standards and paying the medical bills. Those who spoke for the medical profession asserted that the program violated the right of the physician to negotiate his fee because the state health agencies fixed the amounts to be paid within a rational maximum. There was also criticism because the Children's Bureau had stated that physicians could not charge, nor the wife pay, an amount above that paid by the state.77

Organized medicine urged that instead of services by the Children's Bureau to mothers and children, cash grants for medical, hospital, and nursing care should be made to the wives of enlisted men. With cash grants in operation, the AMA argued, the physician would apply his own means test and could negotiate his fee with all wives. Cash grants would also remove from the program any control over the quality of medical care since no agency would know how much or what kind of medicine was purchased with the grant.

In June, 1943, the House of Delegates of the AMA adopted a resolution on the EMIC program:

That the action of the Federal Government in making funds available for maternal and infant care for the wives and infants of enlisted men be approved, and that adoption be urged of a plan under which the Federal Government will provide for the wives of enlisted men a stated allotment for medical, hospital, maternity and infant care, similar to the allotment already provided for the maintenance of dependents, leaving the actual arrangements with respect to fee to be fixed by mutual agreement with the wife and the physician of her choice.78

Spokesmen for the AMA were resentful of any implication that
the issue of cash allotments was the schedule of fees to be paid for service. Dr. W. W. Bauer speaking for the AMA stated that the resolution recommending cash allotments had nothing to do with the amounts allotted. Dr. Bauer argued: "The problem in the mind of the medical profession is the problem of Federal control and the feeling that there is not sufficient opportunity for the program to be controlled in the states where it serves and where the needs of the locality are best known.

Some of the state plans submitted for Bureau approval included proposals for cash allotments; other plans would have permitted patients to pay supplementary fees to physicians and hospitals. Once the attack had been launched by the AMA many state and county medical societies passed resolutions condemning the administration of the program. By mid-summer, 1943, a test case was brought before the people of Ohio. The Ohio State Health Agency had submitted a plan to the Children's Bureau for putting EMIC into operation. While negotiations were going forward between the state and federal agencies, the Council of the Ohio State Medical Association disapproved the plan. Immediately the Governor and the state health officers were deluged with demands that the EMIC program be put into operation without delay. Newspapers of all political affiliations strongly criticized the medical society and joined in support of the program. The effect of the Ohio test case was felt throughout the country: despite the opposition of state medical associations, state after state submitted plans until by March, 1944, all 48 states had EMIC programs.

However, the issue of cash allowance as payment for service was
not dead. In September, 1943, Congressman Smith of Ohio offered an amendment to a deficiency appropriation bill requiring that medical and hospital care be provided in the form of cash allotments, but the amendment was overwhelmingly defeated by a vote of 115 to 8. Then the AMA requested a public hearing in the spring of 1944 before the subcommittee of the House Appropriations Committee that was in charge of the EMIC appropriation.

This hearing was granted and testimony was presented by representatives of the AMA plus the California, Minnesota, New York, Iowa, New Jersey, and Louisiana State Medical Associations. Representatives also appeared from the Committee of Physicians for the Improvement of Medical Care, the American Legion, the National Congress of Parents and Teachers, the CIO, the Young Women's Christian Association, and the Women's Trade Union League.

The published report of the hearings on the 1945 appropriation bill shows that the testimony covered all of the controversial issues thoroughly. However, the only testimony offered in favor of a plan of cash allowances to the wives came from the AMA and the state medical associations. The American Legion, basing its opinion on 19 years of experience, supported direct payments to physicians and hospitals and opposed cash allowances. The Committee of Physicians for the Improvement of Medical Care also supported direct payments. A resolution of the Board of Trustees of the American Hospital Association endorsing the purchase of hospital care by direct payment to hospitals on a cost basis was introduced in the testimony. Before completing its hearing the Appropriations Committee received further testimony from the
Children's Bureau, reviewing fully the principal issues raised by the AMA and many of the details of administration.88

The language of the 1945 Appropriation Act remained the same as that in the former acts, with the exception of the addition of a clause to broaden the group of beneficiaries to include army aviation cadets and a provision to allow the use of part of the grants to states for state administration.89 Neither in the House or Senate appropriation committee reports, nor in the debate on the floor of either house was the question of cash grants or supplemental fees to physicians raised.90 The Congress explicitly re-affirmed its original purpose, that payments for medical care should be made directly to the physicians, hospitals, nurses or others. Thus Congress gave tacit support to the general policies of the Children's Bureau.91

When the House of Delegates of the AMA held its annual conference from June 12 to 15, 1944, the EMIC program was still clearly a matter of concern. The report of the Reference Committee on Legislation and Public Relations, as adopted by the House of Delegates, approved the bill introduced by Congressman A. L. Miller of Nebraska.92 The Miller bill (H.R. 4663) provided for the transfer to the Federal Security Administration and Public Health Services the functions of the Children's Bureau with respect to health. The bill did not provide for the transfer of all agencies dealing with health. The House of Delegates especially favored the transfer of the EMIC program to the Public Health Service. The report of the AMA Bureau of Health Education stated that the EMIC program "is a possible trial balloon, bridghead or entering wedge looking toward the extension of medical service in point of
time beyond the duration of the war and in breath of scope, both as to
kinds of service and as to groups served."93

The AMA attack on EMIC now took the form of an effort to trans­fer the whole EMIC program and the medical functions of the Children's
Bureau to the U.S. Public Health Service where the "aims of the
Children's Bureau can be curbed." To quote this supplemental report:

Among other things it (the Miller Bill) would remove the Children's
Bureau from the Department of Labor to a place where it more
properly belongs, and the Council feels that such a transfer might
aid in curbing the present aims of the Children's Bureau, which
apparently seems to be chiefly the socialization of medicine in this
country. Furthermore, the Children's Bureau has never been willing
to accept good scientific opinion in the conduct of its affairs but
has relied on a hand-picked committee, many of the members of which
have been powerless to prevent actions of which they did not
approve.94

Another criticism of the Bureau's administration of the EMIC
program was the charge that a physician's fee of $35 for antepartum
care, delivery, and six weeks' postpartum care was too low. City physi­cians complained that with their higher costs and greater contributions
of time to free clinics the obstetrical fee was too low in an urban
area.95 The Children's Bureau justified this payment on the basis of a
study, made by the AMA in 1938-1939, of fee schedules set by county
medical societies. This study showed that the nationwide average fee for
delivery fell between $18 and $42, with a median of $25; to this $25
median, the Bureau added $10 for antepartum care.96

After a series of conferences with officials of the AMA and
agencies representing servicemen, the Children's Bureau in August, 1944,
amended its administrative policies to permit differential rates of
payment to specialists and individually adjusted payments to physicians
for cases that required an exceptional amount of care by the physi-
cian. Annual per capital payments were also established for the
care and health supervision of infants by physicians in their offices
and for the purchase of services in child health conferences.

The Emergency Maternity and Infant Care Program was officially
terminated on May 20, 1949. Liquidation of the program was begun on
July 1, 1947, in accordance with Congressional action specified in the
Appropriation Act for 1948. Services continued to be available to
women and children who had been eligible for care as of June 30, 1947.
Under the provisions of regulations issued to the state agencies during
May, 1948, all maternity care provided under the program to eligible
cases had to be completed prior to June 1, 1948, and no maternity care
could be authorized after June 30, 1948.

After the President's proclamation of a national emergency on
December 16, 1950 (the start of the Korean War), inquiries were made of
the Children's Bureau from various sources as to the possibilities of
again providing emergency maternity and infant care for the wives and
infants of men in the armed forces. The Children's Bureau arranged
meetings with physicians, representatives of state health departments,
of hospitals and other groups who had been active during the EMIC pro-
gram. Members of the American Medical Association, American Academy of
Pediatrics, National Federation of Obstetrical and Gynecological
Societies, American Hospital Association, Association of State and
Territorial Health Officers, Association of Maternal and Child Health
and Crippled Children Directors, and American Public Health Association
attended a series of conferences from February 3 to April 4, 1951.
The meeting on April 4 was a general conference attended by representatives of each of the professional organizations. Separate consultations were also held with a group representing the American National Red Cross, the Army, the Navy, and Air Force Relief Organizations, the American Legion, and the Veterans of Foreign Wars.100

At each of the conferences it was emphasized that consultation was not for the purpose of determining whether an emergency maternity and infant care program should be re instituted. The purpose of the conferences was to evaluate the first EMIC program and to obtain suggestions for a new program. The results of the conferences were summarized in a series of broad policies:

(1) A new program, if established should not become effective until 60 to 90 days after the authorizing legislation and should be terminated at the end of the national emergency.

(2) Coverage should include the wives and infants of enlisted men eligible for dependents allowances (pay grades E1-E7) and unmarried mothers and their infants if the father of the child is in military service and paternity is acknowledged or is legally established.

(3) Medical nursing, and hospital care should be provided for the mother during pregnancy, labor, and the post partum period up to six weeks following delivery or up to one year following delivery for any complication resulting from pregnancy or labor.

(4) Medical, nursing, and hospital care, including supervision care for healthy children should be provided for infants during the first two years of life.

(5) The responsibility for administration should be vested in the Children's Bureau and in state health agencies which would administer the program under plans approved by the Children's Bureau.

(6) The program should be financed by Federal funds with the Congress authorizing appropriations in the amounts needed. Administrative funds should be available to the Children's Bureau and the state health agencies at least 60 to 90 days before funds are allocated for the provision of services.

(7) Hospital standards should show that adequate provision is made
for safeguarding hospital maternity and infant cases.

(8) Medical standards should show that adequate provisions are made for safeguarding medical maternity and infant care.101

The proposals suggested by the Children's Bureau conferences were similar to the EMIC program of World War II with three major differences. One of these differences was that only infants under one year were included in the first EMIC program, while the new proposals included pre-school children up to five years of age. Another major difference was that wives and infants of enlisted men in the seven lowest pay grades were covered in the program as contrasted with those of men in the four lowest pay grades of the original. Finally, under the old system administrative funds were not appropriated until the later months of the program whereas the new proposal included adequate federal administrative funds for the crucial 60 to 90 days before services started. At the time, Congress failed to act on the suggestions of conferences.

In 1956, however, Congress enacted the Servicemen's Dependents Act, which in effect, partly replaced the EMIC program. Servicemen's Dependents Act provides health services for wives and dependents of men in the armed forces either at military installations or through civilian resources. The program pays hospitals and physicians directly according to a schedule of charges.102

The World War II EMIC program was in effect from 1943 through June 30, 1948 (the cut-off date on authorization of new cases) during which more than one million babies were born under the program. The
overall cost of the program during the entire period of the operation was approximately $133,000,000. Almost all of the money was allotted to the states for maternity care. 103

The number of infants authorized for care was over a quarter of a million. Beginning with a few hundred maternity cases in the state of Washington in 1941, the monthly average load of new cases throughout the nation rose to a peak of over 42,000 maternity cases by June, 1944. After that time the number of new cases declined at first gradually, and then more rapidly. In November of 1946 the new maternity case load was only about 8,000. The program reached its peak around the middle of 1944; in June of that year almost 47,000 maternity and infant cases were authorized for care. During 1944 and the first six months of 1945, over 40,000 cases on the average were accepted each month. 104 After that time, the number of new cases declined at first gradually, and then more rapidly. The Children's Bureau reported that about 85 percent of the wives eligible for care applied for services. At the height of the program one out of every seven births in the United States was cared for under the program. Almost all of the money was allotted to the states for medical, nursing, and hospital care. Starting July 1, 1944, Congress allotted approximately 3 percent of the appropriations to the states for the administration of the program. In the last three years of the EMIC program the average cost of maternity care was $92.49 and the average cost of completed infant cases was $63.89. 105 The EMIC program turned out to be the largest single public maternity care measure undertaken in this country.

The administration of the EMIC program was complicated by three
major problems. First, the EMIC program was not based on substantial legislation; instead the program was introduced and continued through a series of appropriation bills rather than through the adoption of new legislation by Congress.

Another prevalent criticism of the program involved the lack of adequate administrative preparation for the program before the states were overwhelmed by large numbers of applications. The Children's Bureau and the state health agencies did not have time to prepare rules and regulations or to train personnel. Part of the fault was with the Children's Bureau which underestimated the demand for services. As soon as Congress appropriated funds, the Bureau gave wide publicity to the program and urged those entitled to the services to apply to state health departments for the necessary forms and directions. Before the states had time to prepare the forms and procedures, the deluge of applications began.

The final criticism of the EMIC program dealt with the lack of adequate funds to administer the program. Neither the Children's Bureau nor the state health agencies had sufficient funds for administration. It was not until EMIC grew to huge proportion that Congress allowed $2\frac{1}{2}$ percent of its appropriation for the fiscal year ending in 1945 to be expended for state administration. Even that amount feel short of actual needs.

Despite the administrative difficulties of the EMIC program, the benefits furnished wives and infants of servicemen should not be overlooked. Thousands of other mothers and infants benefited indirectly through the improvement of hospital facilities and through the educational
value of learning from EMIC patients what was involved in good medical care for the mother throughout pregnancy, at delivery, and after the baby's birth. Minimum standards were established for hospital, maternity, and new-born service for the first time in many parts of the country. The EMIC medical advisory committees appointed by state and local departments were a powerful force in maintaining high quality of care under the program by recommending standards of prenatal care, establishing lists of consultants competent in specialties, and by urging the general practitioners to call specialists. The December, 1949, issue of the American Journal of Public Health summarized the accomplishments of the EMIC program:

It is probable that the most important long-range influence of the program was its emphasis on quality of care, which not only affected the mothers and infants who received direct services, but raised the local level of maternal and child care in entire areas, where that level had before been low. Minimum standards were established for hospital, maternity, and newborn services for the first time in many parts of the country. The local health departments were a potent force in maintaining a high quality of medical care under the program by recommending standards of prenatal care, establishing lists of consultants competent in various specialties, and by urging the general practitioners to call the consultants who were made available under the program.

The EMIC program emphasized the shortage of adequate hospitals in the country and contributed indirectly to the passage of the Hill-Burton bill in 1946. More centers for child-health services and more maternity and pediatric beds in hospitals became available as a result of this law, which authorized a program of grants to states, including $3,000,000 for state-wide surveys and planning and $75,000,000 annually for five years for construction of hospitals, health centers, and related facilities. Two-thirds of the cost of building and equipping
such facilities was to be borne by the sponsors of the individual projects—state, county, or city institutions, or private, nonprofit hospitals. The U.S. Public Health Service was to administer the act.
NOTES

1 Fortunately grants to states for maternal and child health and crippled children services had been increased in 1939, and this permitted the states to hold the line in the face of wartime shortages of medical and nursing services.


5 During the war years, the cost of hospital care for crippled children increased almost 100 percent.

6 U.S. Children's Bureau, Crippled Children on State Registers and Services for Crippled Children, Calendar Year 1941, 1942, and 1943 (Washington, D.C., May 24, 1944), multigraphed chart.


11 Ibid., pp. 1-2.

12 U.S. Public Health Service, Transactions of the Conference of the State and Territorial Health Officers, XXXIX (1941); Ibid, Proceedings of the Conference of the United States Public Health Service with the State and Territorial Health Officers, XL (1942).


15 Children's Bureau, Building the Future, pp. iii-v.

16 Commission on Children in Wartime, "Goals for Children and Youth as We Move from War to Peace," Public Welfare, II (1944), 153.

17 Children's Bureau, Building the Future, pp. 10-14, 153-154.

18 Ibid., 12-14.

19 Ibid.

20 Ibid., p. 13.


22 Cited in Ibid., pp. 1-2.


25 Ibid., p. 3.


27 S. 1318, 78 Cong., 1 Sess. (1943).


29 Children's Bureau, Building the Future, pp. 8-11.

30 Edwin F. Daily, Memorandum on State Crippled Children's Services, November 4, 1947, CBP, NR, RG 102, Box 45.


Ibid.

Ibid., pp. 742-743.

Katherine F. Lenroot, "The Battle for Child Health," *Parents' Magazine*, January, 1943, pp. 30-31; the withdrawal of doctors and nurses for the armed services heightened the crisis; the shortage of physicians meant that thousands of women had to go to untrained midwives.


Ibid., the Washington program included only the counties of Pierce and Thurston. Under the plan prenatal care was given at Fort Lewis by the army medical service for women living near the Fort and in prenatal clinics for those living in the surrounding areas. A maternal and child health committee composed of select physicians and public health officials was established which set physician's fees and supervised the operation of the program. A $25 fee for medical care during labor and the post-partum period was agreed upon in the committee. A special all-inclusive rate of $50 for 10 days' care was arranged with hospitals near the base.


U.S. Children's Bureau, "Recommendations of the Committee on Maternal and Child Health of the State and Territorial Health Officers, March 27, 1942" (Mimeographed), CBP, NR, RG 363, pp. 5-6.

Martha M. Eliot, "Children in Relation to War" (lecture given at the Philadelphia Pediatric Society, November 10, 1942), CBP, NR, RG 159, pp. 5-6.

Ibid., p. 1.

Ibid., p. 7.
The government's allowances to dependents of privates and non-commissioned officers were not sufficient to pay the costs of maternity care. The allowances from the government was only $28 a month for the wife, $40 for a wife and one child, with $10 added for each additional child. To these amounts were added $22 a month deducted from the basic pay of the serviceman. Maternity care, including medical and hospital care during pregnancy and after the baby was born, cost on the average $70 per case.

Katherine F. Lenroot, Wartime Needs, pp. 11-12.

Ibid.


Ibid., during 1942, 29 state health departments spent more than $650,000 of their maternal and child-health funds A and B for the medical and hospital care of enlisted men's wives and infants.


These states were Alabama, Arizona, Arkansas, California, Connecticut, Hawaii, Idaho, Illinois, Indiana, Maine, Maryland, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming.


U.S. Statutes at Large, LVII, Part 1, p. 21.


Congressional Record, 78 Cong., 1 Sess. (1943), LXXXIX, Pt. 5, pp. 7021, 7095-7103.

A factor in the establishment of EMIC was apparently the "harrowing" tales Congress had heard of men returning from World War I to find themselves deeply in debt for medical services rendered to their families while they were away fighting.

^Edwin F. Daily, "The Emergency Maternity and Infant-Care Program" (unpublished speech given before the Tri-State Hospital Assembly, Chicago, Ill., May 10, 1944), CBP, NR, RG 363, Box 159, p. 2.

^U.S. Children's Bureau, Memorandum to State Health Agencies from the Director of the Division of Health Services on the Subject of Medical and Hospital Obstetric and Pediatric Care for Wives and Infants of Men in Military Service (unpublished report, May 1, 1942), CBP, NR, RG 102, Box 47.


Circular No. 13; EMIC Circular No. 1; forms for requesting service were made available to mothers through local public health nurses, public welfare workers, and Red Cross volunteers, in prenatal clinics and at military posts. The mother brought the form to her physician who after examining the patient sent the request to the state health department along with a statement that he would provide the care. If the physician was considered qualified by the state agency and the hospital met acceptable standards, care was usually authorized by the state health agency within 24 hours after the request was received. Physicians and hospitals were paid after the care had been completed and satisfactory records submitted to the state agency.

^U.S. Children's Bureau, Memorandum from the Chief of the Children's Bureau to the State Health Agencies on Purchase of Hospital Care under Crippled Children's or Maternal and Child Health Programs, July 23, 1942, CBP, NR, RG 363, Box 48.

^Sinai and Anderson, EMIC, Appendix xvi; also see U.S. Children's Bureau, Memorandum on Revised Policies for the Purchase of Hospital Care, April 15, 1944, CBP, NR, RG 363, Box 48. More or less arbitrarily, the Bureau had determined that the cost of ward care should be estimated as 85 percent of the average per-diem care of the whole hospital.
Edwin F. Daily, Report to State Health Officers on EMIC and Child-Health Services (unpublished report given at the Annual Meeting of the Association of State and Territorial Health Officers with the Children's Bureau, March 20, 1944), CBP, NR, RG 102, Box 50.


Circular No. 13, Revised April 10, 1943.


Ibid.


House of Delegates, Proceedings of the AMA 93rd Annual Session (June, 1943), pp. 70, 82-83.


Ibid., p. 508.

U.S. Department of Labor, Interoffice Communication from the Solicitor, Douglas B. Maggs, to Miss Katherine F. Lenroot, CBP, NR, RG 102, Box 87; U.S. Children's Bureau, Memorandum to State Health Officers and Maternal and Child Health Directors, July 6, 1943, CBP, NR, RG 102, Box 87.


Ibid., 848.

Ibid.

Congressional Record, 78 Cong., 1 Sess. (1943), LXXXIX, Pt. 6, pp. 7767-7779.
Even though the state agencies had the main burden of administering the EMIC program, no federal funds were available until July, 1944, to provide for administrative costs. About $2,700,000 or approximately 35 percent of the total appropriation for EMIC after July, 1944, was allotted to the states for administration of the program.


U.S. Children's Bureau, Memorandum to the State Health Agencies on EMIC, May 4, 1948, CBP, NR, RG 102, Box 46.

U.S. Children's Bureau, Principles to be Considered in Proposals for an Emergency Maternity and Infant Care Program for Wives and
Infants of Enlisted Men Based on Consultation with Various Organizations (unpublished report prepared by Martha M. Eliot, 1951), CBP, NR, RG 102, Box 58, pp. 1-6.

100 Ibid., p. 4.


103 U.S. Children's Bureau, The EMIC Program (a report prepared for the National Security Resources Board, December 17, 1948), CBP, NR, RG 363, Box 159, p. 6.

104 Ibid., p. 7; of the more than 1,450,000 cases authorized, about 84 percent were maternity cases and 16 percent were infant cases. The proportion of infant cases increased during the course of the program. In the period January-June, 1944, the number of infant cases authorized represented 10 percent of the total cases authorized; a year later, the period January-June, 1945, infant cases were over 15 percent of the total cases authorized. In the period January-June, 1948, infant cases represented over 55 percent of total cases authorized.

105 Ibid., p. 9; the average cost for maternity care included cases where complete maternity care was not given, as for example, when a woman applied for care later in pregnancy, or moved out of the state, or withdrew her application before the care was completed. In some of these cases, the total cost included only a part of the maximum medical fee. In the case of infant costs, the figures applied only to those infants for whom separate applications for care were made under the program. Health supervision and immunizations were often furnished through well-child conferences with no payment from EMIC funds.


The period between 1945 and 1950 was spent in shifting from intensive wartime activities to a program of on-going permanent activities. Once the change-over was completed, the Bureau concentrated on strengthening the federal grant-in-aid programs through increased federal funds. In 1946 and again in 1950, Congress amended Title V of the Social Security Act to increase the annual appropriations authorized for each of the Bureau's medical programs. These increased funds enabled the state health agencies to broaden and expand their child health programs. Other crucial developments occurred during the post-war decade. Under Truman's Reorganization Plan No. 2 in 1946, the Bureau was transferred with all its functions but those of child labor from the Department of Labor to the Federal Security Agency. In 1948, the Bureau in cooperation with the American Academy of Pediatrics conducted a nationwide survey of child health services. In 1950, Dr. Eliot became the fifth Chief of the Children's Bureau, replacing the retiring Miss Lenroot.

The return of peace brought a renewed effort by the Children's Bureau to increase federal appropriations for child health services under Title V of the Social Security Act. Pressure to increase appropriations had been expressed in the platforms of both major parties even
prior to the end of the war. The 1940 Democratic platform, in addition to a social security plank, contained a general statement favoring expanded efforts in maternal and child care. The Republican platform for 1944 explicitly supported maternal and child health in the party platform.¹ The plank stated:

Our goal is to prevent hardship and poverty in America. The goal is attainable by reason of the productive ability of free American labor, industry, and agriculture, is supplemented by a system of social security on sound principles.

We pledge our support of the following:

(3) A careful study of Federal-State programs for maternal and child health, dependent children, and assistance to the blind, with a view to strengthening these programs.
(4) The continuation of these and other programs relating to health and the stimulation by Federal aid of State plans to make medical and hospital service available to those in need without disturbing doctor-patient relationships or socializing medicine.²

Similarly, the platform of the Democratic party for 1944 gave general endorsement to various health and public assistance programs. The National Commission on Children in Wartime in 1945 and many other national organizations advocated increases in Federal grants to the states for maternal and child health and crippled children services. President Truman proposed a comprehensive national health program in a message to Congress on November 19, 1945. Among the proposals were to increase federal grants for maternal and child health services.³

In March, 1945, the House passed a resolution (H.R. 204)¹ requesting that the Ways and Means Committee obtain information regarding the need for amending and expansion of the Social Security Act.⁴

This committee conducted a study which lasted one year. On July 15, 1946, H.R. 7037, which incorporated the committee's recommendations for changes to be made during that session of Congress, was introduced.⁵
Amendments proposed in H.R. 7037 were considered to be relatively non-controversial and to meet some of the most immediate needs for changes. On July 25, the House Committee on Labor recommended passage of H.R. 3922, called the "Maternal and Child Welfare Act of 1946," which provided for: "The general welfare by enabling the several states to make more adequate provisions for the health and welfare of mothers and children and for services to crippled children." No action was taken on the bill at this time.

In the meantime, on July 26, 1945, Democrat Senator Claude Pepper of Florida had introduced S. 1318, a companion to H.R. 3922, for himself and Senators Walsh, Thomas Hill, Chavez, Tunnell, Guffey, LaFollett and Aiken. The Senate Committee on Education and Labor held hearings in June on the "Papper Bill" (S. 1318) but decided not to attempt to complete consideration of it so late in the session. This committee on June 27 did recommend virtually tripling the appropriations authorized in the Social Security Act for grants to states for maternal and child health services, services for crippled children and child welfare services. A joint resolution to this effect (S.J. 177) was introduced by Senators Taft and Pepper on July 15, 1946, but was not acted upon. When the bill to amend the Social Security Act (H.R. 7037) came over from the House, the Senate Committee on Finances recommended raising the amounts for each section 1, 2, and 3 of Title V to the following amounts: maternal and child health services, $15,000,000, crippled children, $10,000,000, and child welfare services, $15,000,000.

With regard to need for extending services, the Senate Finance Committee stated:
... the lives of at least one-half of the babies who die in their first year could be saved if they were provided the kind of care medical science knows how to give ... At the end of the last fiscal year, there were 20,000 crippled children known to state agencies to be in need of care who were not receiving such care because of lack of funds ... The need for extending programs for children with rheumatic heart disease and with cerebral palsy was pointed out.

The report further stated:

... the Committee on Education and Labor (which considered S. 1318) has advised us that the whole problem of a health and welfare program would have to be given thorough study at the next session. Because of the immediate need for additional funds to expand the present program of Title V of the Social Security Act, however, it is recommended that, pending study of a more complete program, the funds authorized to be made available under Parts 1, 2, 3, and 5 should be increased the amounts set forth in the committee's amendments.

H.R. 7037 passed the Senate on July 30, 1946. On August 2, the conference report was accepted in both the House and the Senate and on August 10, the bill was signed by the President Truman becoming Public Law 719.

As finally enacted, the 1946 amendments extended Title V of the Social Security Act to the Virgin Islands, Congress increased from $5,820,000 to $11,000,000 the amount authorized by the Social Security Act for annual appropriations for grants to the states for maternal and child health services. This amount was appropriated for the fiscal year ending June 30, 1947 (Public Law 663 approved August 8, 1946). Congress increased from $3,870,000 to $7,500,000 the amount of annual appropriations authorized for grants to the states for services for crippled children. This amount was appropriated for the fiscal year ending June 30, 1947 (Public Law 663).

The amount of straight grants were increased proportionately
in each of the three programs (maternal and child health, crippled children, and child welfare). With respect to both maternal and child health services and crippled children services, the proportion of "Fund A" and "Fund B" were changed so that each became 50 percent of the total amount authorized. Thus, one-half ($5,500,000) of the amount authorized under Title V, section 1 was to be allotted as follows: $35,000 for each state and the remainder allotted to the states in the proportion that the number of live births in the United States for the latest calendar year for which census figures were available. One-half ($3,750,000) of the amount authorized was to go to state crippled children agencies. This meant $30,000 for each state and the remainder according to the need of each state after taking into consideration the number of crippled children in the state and the cost of furnishing services to them. The other half ($3,750,000) of the amount authorized, for which state matching was not required, was to be allotted to the states according to the financial need of the state for assistance in carrying out its state plan.14

Immediately after Congress appropriated increased funds for child health services in August, 1946, the Children's Bureau consulted with its advisory committees and the Association of State and Territorial Health Officers to develop new federal-state programs.15 It was agreed that increased effort should be put into (1) developing new programs for children with rheumatic fever, cerebral palsy, hearing defects, and other crippling conditions, (2) demonstrating school health service projects in selected areas, (3) further development of maternity care programs, (4) increasing and improving facilities for
children and (6) promoting mental hygiene programs for children.\textsuperscript{16}

The Bureau decided that part of the increased appropriation would be used to set up a number of maternity demonstration projects. The purpose of the projects, the first of which was opened in Tuskegee, Alabama, was to demonstrate "what might be done in getting comprehensive maternity care to groups of women who now often lacked even the most elementary care."\textsuperscript{17} Most of these demonstration projects provided complete care, including medical, nursing, and medical social services; facilities for diagnostic and treatment services; care in hospitals, convalescent homes, as well as after care services necessary to safeguard medical gains.

During 1947 with the aid of the increased federal grants, notable progress was made in broadening the scope of maternal and child health services.\textsuperscript{18} By the end of 1947, 43 states had organized some services for the protection of premature infants. Sixteen states had made provision for complete maternity care for a limited number of mothers in specific areas, while 23 states employed obstetricians as consultants to provide clinical consultation to practicing obstetricians.\textsuperscript{19} Medical treatment was provided by 13 states for specified groups of infants and children under school age and 14 states provided for medical examination of school children. A total of 45 states reported to the Children's Bureau dental units as part of their maternal and child health services. Eighteen of these states provided for corrective dental service either at clinics or in dentists' offices.\textsuperscript{20} Increasing emphasis had been placed on the importance of mental hygiene services, in contrast to scattered programs before the war, and by 1947
14 states had some kind of mental health project in operation. Participating states spent a total of approximately $1,000,000 of their total maternal and child health funds on the training of personnel in 1946-1947.

With larger federal grants available the Children's Bureau showed an increased interest in promoting services to children with cerebral palsy. At the time this group of children ranked second to those with poliomyelitis on state crippled children registers. In the calendar year 1947, more than 40,000 cases of acute cerebral palsy were reported to the states. In March of that year, the Bureau called a conference of medical specialists and professional persons from related fields concerned with the care of children with cerebral palsy. This conference, the first of its kind, drew up recommendations to be used as guides by the Children's Bureau and by state crippled children's agencies. By the end of 1947, 12 states had started special programs for children with cerebral palsy, and by 1950, 17 states had instituted cerebral palsy services and several more were planning such services.

By 1947, the number of health departments operating rheumatic fever programs had increased to 22 states, and nine states had programs of service to children with impaired hearing. Five of them developed as special projects. By 1950, 25 states agencies assisted with federal funds had established special programs for children with rheumatic fever. Three states used part of their federal grants to establish training fellowships for graduate work in the field of rheumatic fever. However, the programs in most of these states reached only a limited number of children suffering from this disease.
State crippled children's agencies gave increased attention to children with polio. All states provided some type of service for children with poliomyelitis. In 1947 and again in 1949, under sponsorship of the Children's Bureau representatives of the National Foundation for Infantile Paralysis came together with representatives of state crippled children's agencies and the Bureau staff to develop closer cooperation between private and public agencies for the treatment and rehabilitation of children attacked by polio.25

Before the passage of the Social Security Amendments of 1946, funds for services to crippled children--both federal grants and funds from state sources--had been inadequate to provide full medical care. But the increased funds for services to crippled children made it possible for states to supply the necessary medical services, to renew emphasis upon prevention of crippling conditions by programs of pediatric care, and to expand state programs to include care for children with crippling conditions such as rheumatic fever, cerebral palsy, and hearing defects.

In the spring of 1946, a dispute arose over the organizational location of the Children's Bureau, especially in relation to the Federal Security Agency. Since 1913, the Children's Bureau had been in the Department of Labor. The Federal Security Agency, on the other hand, had been established in 1939 to coordinate the new governmental functions in the fields of public health and social security.26 Proposals to transfer the Children's Bureau into the new agency were advanced at the time of its founding, and also during World War II, but the Bureau rejected any reorganizational proposals to remove it from a department
with cabinet status to one which lacked such status. Further, the Federal Security Agency opposed special programs, such as the maternal and child health programs of the Bureau and instead advocated the development of comprehensive welfare services for all age groups.

The Children's Bureau suffered a setback in its battle against transfer to the Federal Security Agency when Congress passed the Reorganization Act of 1945. Under the terms of the Act presidential reorganization plans not defeated by the Senate and the House within 60 days of the introduction would immediately become effective. The President was determined to rationalize the executive process so he could delegate responsibility and present a united front in his efforts to enact health legislation. On May 16, 1945, in his Reorganization Plan No. 2, President Truman transferred to the Administrator of the Federal Security Agency the functions of the Children's Bureau, except those relating to child labor. Truman felt that this would strengthen the child care programs by moving them into closer association with the health and welfare programs and permit educational activities of Federal Security Agency. In his message to the Congress accompanying this executive order, President Truman stated:

The child-labor program is the only permanent program of the Children's Bureau that is properly a labor function. The other four—child welfare, crippled children, child and maternal health, and research in problems of child life—all fall within the scope of the Federal Security Agency. The transfer of the Children's Bureau will not only close a serious gap, but it will strengthen the child care programs by bringing them in closer association with the health, welfare, and educational activities with which they are inextricably bound up.

The promotion of the education, health, welfare, and social security of the Nation is a vast cooperative undertaking of the Federal, State, and local government. It involves numerous grant-in-aid programs and complex inter-governmental relations. The
transfer of the Children's Bureau will simplify these relations and make for better cooperation.31

The Administrator of the Federal Security Agency took steps to coordinate the Children's Bureau programs effectively with other agency activities. At the same time he recommended that Congress pass legislation making the Federal Security Agency an Executive Department.32

In an article on "Reorganization of the Federal Security Agency," Mr. Altmeyer, Commissioner for Social Security, said:

The great advantage of the transfer of the Children's Bureau to the Federal Security Agency is that it is brought in closer contact with the other programs of the Federal Security Agency designed to promote the health, education, welfare, and security of the American people. . . . the Children's Bureau will continue to discharge the same functions as formerly in the fields of health and welfare.33

In 1946, after reorganization, and again in 1947, the Bureau's Health Advisory Committee and the Conference of the State and Territorial Health Officers recommended that the Children's Bureau actively promote post-graduate training of physicians and the care of premature babies. The Bureau, beginning in 1948, financed post-graduate training of physicians and nurses in maternal and child health work at a number of colleges and universities, such as Harvard, University of California, John Hopkins, North Carolina University, and the University of Minnesota.34 Special training was also made available to physicians and nurses in audiology, the treatment of rheumatic fever and congenital heart disease, the care of premature infants, epilepsy, and cerebral palsy. In order to better prepare medical personnel for their maternal and child health activities, institutes and educational projects were partially funded by the Bureau. The Massachusetts Department of Public
Health and the Harvard School of Public Health conducted institutes on child growth and development for medical social workers and nurses. In 1954 the California State Department of Public Health with the School of Social Welfare, University of California, established scholarships and internship programs for medical social workers interested in public health. The Cornell New York Medical Center co-sponsored with the Children's Bureau a series of institutes on care of premature infants. Between 1949 and 1954 a total of 109 teams of physicians and nurses attended these institutes.35

The Bureau broadened and extended its activity in behalf of prematurely born infants. Special projects for the care of premature babies (undersized and underdeveloped infants, who weighed less than five and a half pounds) received maternal and child health grants. By 1949, 10 states were supplying care for premature infants in hospitals with special equipment and with specially trained physicians and nurses. Some of these programs provided a system of transportation of premature infants from a wide geographic area surrounding the centers, thus covering large parts of the state. As a result of these activities, states were giving attention to prenatal care, particularly for mothers with complications of pregnancy in an effort to reduce the incidence of prematurity.36

In addition to giving greater attention to prematurely born infants, post-graduate training of medical personnel, and the emotional growth of infants and children, some states added to their health promotion services provision for medical care of certain mothers and children. Sixteen states were purchasing medical and hospital care
for premature infants, on a demonstration basis. These special projects included a program in Alabama that supplied medical care for black mothers; another in Florida that provided care in an area where there were migrant farm workers, and a program in South Carolina served tuberculous expectant mothers. In addition, five states—Illinois, Colorado, Hawaii, Louisiana, and Maryland—provided services for mothers with complications of pregnancy. Three states—Delaware, Kentucky, and Tennessee—established pediatric clinics on a trial basis in limited areas. Child health conferences were broadening their scope to include the mental health aspects of child growth and development. The conferences were directed more toward assisting parents with early social and emotional difficulties in their children, and greater emphasis was placed on the psychological aspects of maternity care.

The Children's Bureau for the first time cooperated with and gave technical assistance to the new international agencies, the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO). From 1949 to 1951, Dr. Eliot was the Assistant Director-General of the World Health Organization, having served as chairman of its Expert Committee on Maternal and Child Health in 1949. The Bureau also sent consultants to eight Latin American counties and arranged for the training of Latin American personnel in the United States.37

In 1949, the Division of Maternal and Child Health carefully reviewed all regulations for both maternal and child health and crippled children programs. In 1950 a detailed compilation of public policy in relation to standards of medical care and the protection of patients' interests was promulgated by the Chief of the Bureau and issued
as part of the Bureau's operational manual. The new regulations required the states to describe their standards for personnel and facilities and to make diagnostic services under the crippled children's program available to any child without charge. On September 4, 1951, Dr. Martha M. Eliot became the fourth Chief of the Children's Bureau.

Another postwar development was the American Academy of Pediatrics' Survey of the National's child health services. As a basis for postwar planning the President of the AAP, Dr. Thomas Parran, in November, 1944, invited the Children's Bureau and the Public Health Service to undertake with the Academy a nationwide study of child health services. The Children's Bureau aided the study, the first comprehensive inventory and analysis of child health services on a nationwide basis ever conducted in this country, by lending Dr. Katherine Bain, Director of the Bureau's Division of Research and Child Development.

The purpose of the survey was to collect data on the basis of which a program could be developed "making available to all mothers and children of the United States all essential preventive, diagnostic, and curative medical services of high quality which used on cooperation with other services for children, will make this country an ideal place for children to grow into responsible citizens."

The study included these major fields of inquiry: pediatric education, distribution, qualifications, and activities of professional personnel, hospital facilities, including outpatient clinics and laboratories, plus health services for children.

The Academy's study on child health services and pediatric
education was completed in 1948 and the report published in April, 1949 by the Commonwealth Fund. The study, based partially on state reports, gave evidence of widespread interest in the extension of child health services but revealed many shocking differences as well.\textsuperscript{41} The Academy report noted the unevent distribution of medical care and health services for children, inadequacies in health child supervision and school health services, plus a lack of outpatient and medical consultant services for children in isolated areas.\textsuperscript{42} The Report arrived at the following generalizations on total volume of medical care for children:

Only 6 percent of all children under five years of age receive service in well-child conferences. Such services are nonexistent in 2,000 counties where 31 percent of the nation's children under five years of age reside.

Three-fourths of the private medical care of children is provided by general practitioners of whom nearly one-half have had virtually no hospital training in child care . . . .

Over one-third of our children are cared for in hospitals which are inadequately staffed and equipped.

Over one-half of our 3,050 counties have no elementary school that offers a health examination by a physician. Twenty-two percent of the nation's children in the five-to-fourteen group reside in these counties.\textsuperscript{43}

In view of these startling discoveries, the American Academy of Pediatrics, through its Committee for the Improvement of Child Health, emphasized: (1) the need for improved undergraduate and graduate training in child care for both general practitioners and child specialists, (2) the need for decentralizing graduate training programs to include hospitals in outlying communities, (3) provision of fellowships for interns who could not otherwise afford to acquire adequate training in child care prior to entering practice, and (4) coordination of decentralized medical training programs with community health services.
for children. In his State of the Union message on January 5, 1949, President Truman recommended expansion of the Social Security programs, and on February 21, he transmitted to Congress drafts of the Social Security bill. On the same day the Chairman of the House Ways and Means Committee introduced H.R. 2892. With respect to Title V of this bill, it made no changes on parts 1 and 2.

The House Ways and Means Committee held extended hearings on this bill and made an intensive study of the child welfare services. The report of the Committee stated, in reference to Child Welfare services that: "Authorization for child welfare services in rural areas or areas of special need would be increased from $3,500,000 per year to $7,000,000. The use of child-welfare funds would be authorized for purposes of returning interstate runaway children to their homes."

On August 15, 1949, H.R. 6000 was introduced incorporating the recommendations of the Committee. The bill passed the House on October 5, 1949 and was referred to the Senate. In 1950, the Senate Finance Committee held extensive hearings on the Social Security Amendment which lasted from February 28 through April 27, 1949.

On May 17, the Committee reported out H.R. 6000. The bill provided for increasing the amounts authorized for each of the three programs to the following amounts: maternal and child health services, $20,000,000; crippled children services, $15,000,000; and child welfare services, $12,000,000.

With respect to maternal and child health services, the committee report stated in part:
Recent reports received by the Children's Bureau from state health departments indicate that because of increased costs, 23 of the 53 states and territories participating in the maternal and child-health program have already, or will soon, find it necessary to curtail some of their services because of lack of funds. The health departments also indicate that demands for services are increasing because of the continued high birth rate.

On services to crippled children the report emphasized:

The cost of providing service to crippled children has risen sharply. Hospital costs make up a large share of expenditures under the program. Between 1939 and 1949, there was an increase from $6.42 to $14.06 in the average operating cost per patient-day in voluntary non-profit hospitals. Recent reports received by the Children's Bureau from the state crippled children's agencies reveal that 37 of them are having to curtail their programs owing to the lack of funds, either by closing clinics or limiting the intake of children awaiting service.

H.R. 6000 passed the Senate on June 20, and on August 28, 1950, it was signed by the President becoming Public Law 734. As finally enacted, the 1950 Amendment increased the amount authorized for maternal and child health services $15,000,000 for 1951 and $15,000,000 for each year thereafter. The amounts of the flat grants were increased proportionally in each of the two programs. These new monies meant increased funds for maternal and child health services throughout the country.

The Children's Bureau had been delegated the authority to organize the work of the national planning committee of citizens for the Mid-century White House Conference on Children and Youth. In December, 1946, the National Commission on Children and Youth meeting with the Children's Bureau formally made the first proposal for a 1950 Mid-century White House Conference. A committee of commission members was appointed to develop plans and make suggestions. This committee worked through 1947 and reported at a meeting of the National
Commission held in Washington, D. C. in January. Congress at the request of the Commission members, appropriated to the Children's Bureau $75,000 to be used in the fiscal year 1949 in planning for the Conference.\(^5\) In April, 1948, the President asked the Federal Security Administrator to arrange for an Interdepartmental Committee on Children and Youth to "assist the Children's Bureau of the Federal Security Agency in cooperation with the National Commission on Children and Youth, and other appropriate national, state, and local organizations in laying the ground work for the 1950 White House Conference on Children."\(^5\) This Committee invited members from the Department of Agriculture, Defense, Interior, Justice, and Labor, the Administrative Office of the United States Courts, the Federal Security Agency, the Housing and Home Finance Agency and the Selective Service System. The Chief of the Children's Bureau, Miss Lenroot, served as Vice-Chairman of the Committee.\(^5\) The Committee issued two reports, *The Needs of Children in Puerto Rico* and *Program of the Federal Government Affecting Children and Youth*. The Interdepartmental Committee and the National Commission on Children and Youth each named a subcommittee to constitute a joint Interim Committee to assist the Children's Bureau in the initial planning for the Conference.\(^5\) At the President's request, the governors of the states and territories named committees of professional and lay citizens and of public and private agencies to establish plans within their jurisdiction.

In September, 1949, President Truman appointed 52 citizens interested in child health and welfare to serve on the National Committee of the Mid-century White House Conference on Children and Youth.
The National Committee appointed four National advisory councils and four technical committees to help develop plans for the Conference.55 At its first meeting, the Committee on the Midcentury White House Conference defined the focus of the Conference: "The purpose of the Conference shall be to consider how the mental, emotional and spiritual qualities essential to individual happiness and to responsible citizenship can be developed in children and what physical, economic and social conditions are deemed necessary to this development."56 A technical fact-finding committee of experts in the field of child development was asked to prepare a report that would give the Conference a point of departure. A digest of this report was issued under the title "For Every Child a Healthy Personality."

More than 5,000 delegates attended the Midcentury White House Conference on Children and Youth held in Washington, December 3-7, 1950. The members accepted 72 major recommendations based on fact-finding reports submitted to the conference by the advisory committees.

With respect to Maternal and Child Health, the White House Conference stated:

1. Essential to the successful operation of health services at the local level in peace and war, is a full time local health unit with a balanced staff . . .

2. It is imperative that local funds available for this purpose be supplemented with funds and other resources of the state and of the nation.

3. The success of the present mobilization of armed forces, industry, and civil defense is to an important degree dependent on providing adequate health services to mothers, children, and youth.57

With regard to crippled children the Conference recommended:

Services for the handicapped are not always coordinated and are not always based on the needs of the handicapped. There is danger
of the categorical approach in planning and giving special services 
what does not include consideration of the whole child.58

At the Conference more attention began to be given the needs of 
retarded children and mentally disturbed children. Following the 
Conference, the National Association for Retarded Children was formed 
to educate the public, foster research, and stimulate support for 
better services. The Bureau took its first step in service to the 
mentally retarded in 1954 with a grant to California from maternal and 
child health funds for a diagnostic clinic to be set up at the Children's Hospital in Los Angeles. The next year three other states were 
granted maternal and child health funds for similar demonstration projects.

After the Conference, the National Midcentury Committee for 
Children and Youth was formed to publicize the findings, to promote the 
recommendations and to encourage further research. The National Mid-
century Committee worked through state and territorial youth committees 
or commissions. Four hundred and fifty national organizations, wholly 
or partly concerned with children, participated in this follow-up 
campaign as well as the appropriate federal agencies.

During the calendar year 1952, the last full year of the Truman 
Administration, state reports to the Children's Bureau showed that, 
under continuing programs administered by state health agencies, 
180,000 mothers attended prenatal clinics, and 433,000 infants and 
576,000 preschool children attended well-child conferences, represent-
ing a total of about 1,190,000 visits. There were also almost 4.4 
 million nursing visits for mothers, infants, and preschool children.59
In addition, there were about 2,700,000 examinations of school children and almost 2,800,000 dental inspections of preschool and school children, and about 3.7 million immunizations against diphtheria and smallpox were given. These figures compare favorably with the 1946 child health statistics when 130,000 expectant mothers attended prenatal conferences, 180,000 infants and 275,000 preschool children attended well-child conferences, 1,600,000 school children were given health examinations by physicians and 3,900,000 children received immunization against diphtheria and smallpox. Maternal mortality was reduced 91 percent between 1935 and 1952, and infant mortality 50 percent.

State and local funds for maternal and child health services had steadily increased during the postwar years. In 1940, total expenditures for maternal and child health services were $7,300,000, of which $4,200,000 was from state and local funds and 3,100,000 from federal funds. By 1952, the total amount of such planned expenditures had increased to $20,000,000, of which $7,000,000 was derived from state and local funds and $13,000,000 from federal funds.

More crippled children received care during the calendar year 1952 than in any previous year. Unduplicated counts of children under state care showed that 238,000 children were provided physicians services in 1952 compared with 228,000 the previous year. The conditions for which these children received care included the following: congenital malformations, conditions of bones and organs of movement, poliomyelitis, cerebral palsy, ear conditions, burns and accidents, rheumatic fever, eye conditions, epilepsy and other diseases of the nervous system, tuberculosis of the bones and joints, and birth injuries.
State and local funds increased steadily. At the beginning of the calendar year 1946, the state reported that their anticipated expenditures for the year were $9,500,000, of which $5,500,000 was from state and local funds and $3,700,000 from federal funds. By 1952 total expenditures had increased to $14,000,000, of which $3,000,000 was from state and local funds and $11,000,000 from federal funds. At the same time, state health agencies gradually developed and expanded their services, including medical, dental, nursing, and nutrition services for mothers, infants, and preschool and school children.

Still, some 700 counties were not served at all by a public health nurse—one of the most important services for promoting the health of mothers and children. Furthermore, in 1953 the Bureau estimated that the number of crippled children with handicaps not orthopedic in nature were nearly 10 times the number with orthopedic handicaps, yet they represented less than half the children receiving physicians' services through state crippled children's programs. Moreover, most of the services during this period continued to be primarily preventive in nature. These services included prenatal and postpartum clinics for maternity patients; child health conferences for infants and preschool children; immunization for children against diphtheria and smallpox; dental inspections; public health nursing services in the home and in clinics; and nursing supervision of midwives.

For child health the postwar years were crucial ones. This period brought new programs, more knowledge of child growth and
development, and a greater community conscience about maternal and infant health care. All of these were important in the reduction of maternal and infant mortality.
NOTES


2Ibid., pp. 408-409.

3Congressional Record, 79 Cong., 2 Sess. (1946), LXXXII, Pt. 1, pp. 10819-10820. The National Commission on Children in Wartime in 1945 and many other national organizations advocated increases in federal grants to the states for maternal and child health services.

4U.S. Congress, House, H. Res. 204, 79 Cong., 1 Sess (1945).


6Ibid.

7Ibid.

8S. 1318, 79 Cong., 1 Sess. (1946); H.R. 3922, 79 Cong., 1 Sess. (1945); under Pepper's bill, all expectant mothers along with those with children under 18 years of age would receive complete health care. At this time Pepper was emerging as one of the leaders of the national health care movement; he had been the chairman of the subcommittee investigating wartime health and education, popularly known as the Pepper Committee.


11Ibid., pp. 10-11.

12Ibid., p. 11.


14Children and youth also benefited from two other pieces of legislation passed by the 79th Congress—the National Mental Health Act and the School Lunch Program. The purpose of the Mental Health Act
(Public Law 487), approved July 3, 1946, was to promote mental health of the people through (1) conducting, assisting and fostering, and promoting the coordination of research relating to the cause, diagnosis, and treatment of psychiatric disorders; (2) training of personnel in matters related to mental health; and (3) developing and assisting states in the use of the most effective methods of prevention of psychiatric disorders and for the treatment of persons with such illness. The United States Public Health Service was to administer the act, which included provisions for grants to the states on the basis of plans submitted by the mental health authorities of the state.


16 Ibid., p. 124.

17 Ibid.

18 The increased federal appropriations under the amendments to the Social Security Act did not become available until 1947.


20 Ibid., pp. 124-125.

21 Ibid., pp. 127, 146.

22 Ibid., p. 127.

23 This bill, popularly known as the Wagner Murray-Dingell bill, was an outgrowth of earlier legislation first sponsored in Congress in 1943. Senator Wagner proposed amending Title II of the Social Security Act to establish comprehensive hospital and medical services for the entire population. Excluded were provisions for federal funds for maternal and child care services, hospital and health center construction, and public health work in the states; the bill died with the expiration of the 78th Congress; S. 1161 and H.R. 2861, 78 Cong., 1 Sess. (1943).


27 Ibid., pp. 19-20.
28Ibid., pp. 20-21.
29Ibid., p. 20.
31See the Reorganization Plan Number 2 Message, May 16, 1946, Truman, Public Papers, 1946, p. 257.
34Christine P. Ingram, "Demonstration Projects in Child Health with Aid of Increased Federal Funds," Journal of Exceptional Children, XIV (1951), 57-60.
40Committee for the Study of Child Health Services, American Academy of Pediatrics, Child Health Services and Pediatric Education (New York, 1949).
41Ibid., pp. 34-36.


Ibid., pp. 30-33.


Ibid., pp. 59-60.

Ibid.

Ibid.; the 1950 amendments made the following changes in Part 3 of Title V (child welfare): (1) increased the appropriations for rural areas or areas of special need from $3.5 million per year to $7 million; (2) authorized using federal child welfare services funds "for paying the cost of returning any runaway child who has not attained the age of 16 to his own community in another state in cases in which such returns is in the interest of the child and the cost thereof cannot otherwise be met;" (3) added the following provisions to Section 521 (a) Part 3: "Provided that in developing such services for children the facilities and experiences of voluntary agencies shall be utilized in accordance with child-care programs and arrangements as may be authorized by the State." A description of the other provisions of the Social Security amendments can be found in Wilbur J. Cohen, "The Social Security Act Amendments of 1950," The Journal of the American Public Welfare Association, XVIII (1950), 226-230.


Ibid.


The National Commission on Children and Youth was appointed by the Chief of the Children's Bureau in 1946 to draw together representatives of national organizations, professional associations, and
selected state and local leaders concerned with children and youth. It succeeded the National Commission on Children in Wartime originally appointed in 1942. The National Commission on Children and Youth was dissolved in 1951 after the White House Conference.


58Ibid., p. 8.

59U.S. Children's Bureau, Summary of the Reports from Official State Maternal and Health Agencies to the Children's Bureau, February 1959 (unpublished report), CBP, NR, RG 6, Box 20, p. MCH-3.

60Ibid., p. MCH-4.

61Ibid., pp. MCH-1-4.


63Summary of Reports, p. CC-1.

64Ibid., p. CC-4.

65Ibid.
The effort to expand postwar health services came at a time when liberals and the Administration were sponsoring a series of health insurance bills in Congress. Most of these bills included some provision for comprehensive maternal and child health services. The successful operation of the Emergency Maternal and Infant Care program gave hope to the President and the Children's Bureau.

Senators Wagner and James E. Murray of Montana, and Representative John D. Dingell of Michigan, all Democrats who had been consistent advocates of social welfare legislation, introduced a national health bill in late May, 1945. In addition to health insurance, federal grants for hospitals and health center construction, it provided expansion of state maternal and child health services.\(^1\)

Because the bill contained a section on finance, the Senate version (S. 1050) to the Ways and Means Committee on Finance and the House version (H.R. 395) to the Ways and Means Committee. Democratic Senator Walter George of Georgia, Chairman of the Finance Committee, gave assurances that the bill would get a hearing but the Committee concerned itself with other matters.\(^2\) The House refused to hold hearings on the bill. To break this impasse, the health bill sponsors decided to introduce a revised bill which would not mention finances...
in order to have it referred to different committees. The sponsors met with President Truman on this matter and decided to time the bill's re-introduction with his special health message to Congress.³

On November 19, 1945, President Truman threw the weight of the federal government behind a proposal for compulsory national health insurance.⁴ He first outlined unmet needs and then presented proposals for their solution. Five major health problems were cited: mal-distribution of professional personnel and medical facilities; inadequate public health services; the need for expanded research and training programs; the high cost of medical care; and the loss of income due to prolonged illness. In order to meet these problems, the President urged the adoption of a national health program which would provide federal grants to construct hospitals and other health facilities and to expand public health services. Grants would also be earmarked for research programs and medical education. To protect against economic insecurity due to illness, the message suggested two systems of social insurance. One system was to cover loss of wages due to sickness and disability, and the other was to provide workers and their dependents with a comprehensive program of medical services pre-paid through social security taxes.

On the matter of child health, the President stated, "The health of American children, like their education, should be recognized as a definite public responsibility." He called attention to the wartime emergency program (EMIC) and to the federal-state cooperative relationship in the promotion of health programs for maternal and child health services, and finally, Mr. Truman promised more generous federal grants
to the states for these purposes.

On the same day, Senators Wagner and Murray and Representative Dingell introduced bills in the Senate and House, S. 1606 and H.R. 4730, to carry out three of the five points of the President's program, namely, expansion of public health services, maternity and child health services, more adequate funds for medical education and research, and a system of prepaid medical costs. Federal aid for the construction of hospitals, the first of the President's five points, had already been provided for in the Hospital survey and Construction Act (Burton Act) which became law in 1946. Insurance benefits to compensate for loss of wages during periods of sickness and disability, the President's fifth point, was provided for in the 1946 Social Security Act. Under Title I of the National Health bill, federal appropriations for maternal and child health and services for crippled children were unlimited, being annually 'a sum sufficient to carry out the purposes of this section.' This financial aid was conditional upon the state setting up a plan approved by the chief of the Children's Bureau. The bill required that the state plan provide for financial participation by the state, personnel standards on a merit basis, and cooperation with other health agencies, demonstration programs, and availability of services to all agencies, demonstration programs, and availability of services to all
mothers and children and crippled children in the state or locality who elect to participate in the benefits of the program." The federal government would pay from 50 to 75 percent of the state expenditures for maternal and child health services, the states with the lowest per capita incomes to receive the maximum federal aid. Special provision was made for the use of the appropriation not only for maintaining services and providing them to mothers and children but, in the case of crippled children, for locating these children and for devising effective measure inclusive of demonstration as part of a treatment and corrective program. Title I authorized an appropriation of $5,000,000 for the expenses of the Bureau in administering the maternal services and the crippled children's services; Title II provided social insurance under the Social Security system for general medical care to include outpatient, hospital, and dental services to workers paying Social Security taxes along with their dependents. Because the new bill did not outline a system of financing, the Senate version was referred to Senate Murray's Committee on Education and Labor and H.R. 4730 to the House Committee on Interstate and Foreign Commerce.

No action was taken on the House side, but the Wagner-Murray bill was assured of a hearing since Senator Murray was chairman of the Education and Labor Committee. But before the committee scheduled hearings on S. 1606 could get underway in April, 1946, major differences arose over provisions of the health bill.

On March 12, 1946, AFL President William Green wrote to Senator Murray to point out that the welfare provisions of the maternity and child health section of Title I of the Wagner-Murray bill not only
duplicated but even went beyond the services provided in Title II of
the social insurance section. Green feared that the general public
might be confused and interpret the legislation as a vehicle for
expanded welfare services rather than as a social insurance system. He
urged Senator Murray to attach a clarifying amendment indicating that
the Bureau's welfare program would complement and not duplicate the
social insurance feature.\footnote{Senator Murray agreed and passed the
letter on to the President who in turn fully accepted Green's recommen-
dation.} Senator Murray agreed and passed the

Another related problem stemmed from the Children's Bureau
refusal to support the Wagner-Murray bill. The Children's Bureau let
it be known that it had reservations regarding parts of the national
health program sponsored by Senator Wagner. Dr. Eliot and Miss Lenroot
of the Children's Bureau tended to be very conservative in their
estimate of congressional and public support of all aspects of the
program. A defeat might damage the Bureau's child health program.
Furthermore, they regarded with suspicion any proposal which gave other
agencies, such as the Public Health Service, predominant administrative
control over a child health program. They felt that the Bureau had a
special responsibility for the nation's children, and this responsi-
bility took precedence over a general medical program.

The Children's Bureau preferred the Maternal and Child Welfare
bill (S. 1318) introduced in July, 1945, by Senator Claude Pepper of
Florida.\footnote{Pepper's bill had not only bi-partisan support but even the
American Medical Association had shown a friendly disposition toward
the bill.} Naturally, the Children's Bureau and Senator Pepper did
not want to jeopardize the passage of their proposed welfare program by having it linked to the highly controversial social insurance measure S. 1606. In addition, although Title I of the Wagner-Murray bill provided for expanded maternal and child care services, only those covered under Title II, the insurance section of the bill, would qualify for such services. On the other hand, Pepper's bill would provide federal grants for universal coverage, all expectant mothers along with those under 18 years of age would receive complete health care.

In an effort to resolve these differences, the Secretary of Labor, Louis Schwellenbach (speaking for the Children's Bureau) agreed to support S. 1606 by attaching amendments to the National Health bill, first to guarantee that maternity and child health services also be provided to those not covered under the insurance program; and second, to require the Surgeon General, wherever possible, to use the same state health agency employed by the Children's Bureau for administration of the social insurance program. Finally, it was agreed that changes would be made in the bill to avoid duplication of services. Satisfied with this arrangement, Senator Pepper then submitted the required amendments. The amendments removed any financial restrictions on the services for maternal and child health services that might be imposed under the national health program, provided the states furnished part of the funds to pay for the supplementary services. These amendments broadened the scope of the bill to assure the provision of health services to non-insured mothers and children. Finally the Pepper amendments made certain that the Surgeon General of the Public Health
Service would utilize the same state health agency to which grants for
maternal and child health service would be made by the Children's
Bureau. 16

This amendment stated:

Whenever the same State health agency is responsible for the
operation of both the personal health service program under Title
II and the maternal and child health and crippled children's
service under Title I, part B, there will be a unified program for
health and medical care, and preventive and curative service will
not be separated administratively. If, however, in some situations
it is deemed necessary for the Surgeon General to utilize some
other agency than that to which maternal and child health grants
are made, or if the crippled children's agency in a given State is
not the State health agency, the community health services for
maternity care and child health that are characteristically pre-
ventive medical care will be separated administratively from the
curative service provided through Title II or through the crippled
children's service. 17

In short, the Pepper amendments established a clear distinction between
maternal and child health service in the community and personal health
services proposed under S. 1606.

The Senate hearings on S. 1606 began in early April. Miss
Lenroot and Dr. Eliot emphasized the pressing need for expanded
maternal and child health services. As brought out in testimony at the
hearings, three out of four rural counties provided mothers with no
regular monthly maternity clinics under public-health auspices; two out
of three were without monthly well-child clinics; two out of three
counties had no public-health nurse. According to Miss Lenroot,
200,000 mothers a year had their babies without benefit of any medical
attendance.

The Bureau's fear that the National Health bill would encounter
strong opposition proved correct. Although the American Medical
Association approved Title I, the grants-in-aid section of the Wagner-Murray bill, according to Morris Fishbein, the Journal Editor, would make doctors "clock watchers" and "slaves." In December the House of Delegates of the AMA adopted resolutions which: (1) specifically denounced the President's health insurance proposal, (2) urged that no change be made in the present system of medical care until service physicians had returned to civilian practice, and (3) requested that the AMA Board of Trustees embark upon a public education campaign "giving the widest publicity through every available medium, a warning of what adoption of a system of federal control of the practice of citizens." The AMA used its abundant resources in a nationwide effort to obstruct health care reform.

The AMA had powerful allies in its opposition to S. 1606. For example, the American Hospital Association also scored the new Wagner-Murray bill as an opening wedge to complete federal control and operation of the nation's health system. In view of the Association of American Physicians and Surgeons and the National Physicians Committee the bill was "socialized medicine with a vengeance" and was opposed to the bill at all costs.

Both the American Protestant and the Catholic Hospital Associations then followed suit and expressed similar views on the matter. Opposition also came from the American Dental Association whose president had maintained that the National Health bill would create "the greatest bureaucracy the world has ever known ...." Outside the medical profession, a powerful group of special interests lined up to defeat the President's bill within weeks of the
hearing commencement. The American Bar Association, the Christian Science Committee on Publications, the United States Chamber of Commerce, the Fraternal Order of Eagles, the National Grange, and the Women's Auxiliary of the American Farm Bureau Federation, the American Academy of Pediatrics, and the California Physicians Service considered Title II of the National Health bill to be alien to the American tradition of voluntarism. However, most of these groups approved the maternal and child health section of the Wagner-Murray bill.

Endorsement of S. 1606 came from organized labor, the National Consumer's League, welfare organizations, representatives of the ethnic minorities like the American Jewish Congress and the National Association for the Advancement of Colored People, as well as from the newly formed liberal organization, The Americans for Democratic Action.

With mounting opposition from hostile pressure groups and Truman's reluctance to speak out on the health insurance proposal, congressional health sponsors moved to bring the Senate hearings to a close. On July 9, Senator Murray announced to the press the abandonment of efforts on the health bill until the next session of Congress in January, 1947. 25

Opposition to the compulsory health insurance bills of Wagner and Murray which had been introduced during 1945 and 1946 stimulated Senator Robert Taft, conservative Republican from Ohio, to seek an alternative approach to the problem. In May, 1946, while the hearings on S. 1606 were still going on, Senator Taft and Republican Senator Smith of New Jersey and Ball of Minnesota introduced S. 2143, labeled the National Health Act. 26 This bill offered a medical welfare program
for the nation's indigent to be financed through federal grants and administered entirely by the participating states. Specifically, it provided for the creation of a single National Health Agency, to be administered by a National Health Administrator to whom the functions of all existing Federal health bodies would be transferred. This bill would have provided $200,000,000 annually for grants to aid the states to care for indigent. More importantly, those functions of maternal and child health services and services for crippled children of the Social Security Act would be transferred to this new agency. Also included were provisions for the establishment of institutions for the purpose of conducting medical and dental research and health inspection services for all children in elementary or secondary schools in the states. Another section of the bill authorized grants up to $20,000,000 a year for dental services for school children. State plans would provide annual inspection of the teeth of all children in elementary and secondary schools, and dental treatment for needy children. "Need" was to be determined by the school principal. The extent of federal aid to each state for both medical and dental service programs for children was to be determined by a formula based on population and tax paying ability. The effect of the formula was to result in a relatively higher federal subsidy for poorer states.

Major support for the bill came from the American Medical Association, the hospital associations, the insurance companies and others opposed to compulsory health insurance. However, even these groups confined their endorsement for the most part to "the general approach of the bill" or to its "broad aims."
The health bill not only lacked the enthusiastic support of special interest groups, but even the bill's supporters showed little desire to fight for their own measure, preferring to stick with the status quo. On the other hand the same groups which had endorsed S. 1606--organized labor, public health, officials, women's organizations and others--found the Republican bill inadequate. They objected to the fact that the bill would have required a means test as a prerequisite for giving medical care even though, since there was to be no compulsion on a state to submit a health plan, there was no assurance whatever that health care would be made available even to the indigent. Further, those who opposed the bill stated that the bill entirely ignored the need for "the expansion of the present Federal-State cooperative health program and the strengthening of professional education . . . and increased support of medical research." Dr. Eliot, speaking for the Children's Bureau, objected to the fact that the bill would not provide comprehensive child health care.

With this kind of opposition and with the Democrats in control of the 79th Congress, the Republican bill received little attention. Taft, Smith, and Fall joined by GOP Senator Forrest Donnell of Missouri submitted a new version of the Republican health proposal (S. 545) in the 80th Congress. This bill did manage to obtain a slightly more extended and sympathetic hearing but again failed to be reported out of committee.

Concerned by the failure of the Pepper bill even to be reported out of committee, Republican Representative Howell of Illinois introduced the National School Health Services bill (H.R. 1980) in March,
1947. A companion bill was introduced at the same time in the Senate by Republican Senators Saltonstall of Maine, Smith of New Jersey, Democrat Fulbright of Arkansas, Republican Lodge of Massachusetts, Baldwin of Connecticut and Ives of New York. This bill would have established a new grant-in-aid program to assist the states in the establishment and development of school health services for the prevention, diagnosis, and treatment of physical and mental defects and conditions of school children. Provision was also made for demonstration programs and the training of personnel for state and school health services. The Children's Bureau was to administer the act under the supervision and direction of the Federal Security Administrator and with the advice of a School Health Services Board and a National Advisory Committee on School Health Services.

The bill authorized appropriations of $12,000,000 the first year, $18,000,000 the second year, and for each succeeding year "as much as may be necessary to carry out the purposes of this legislation." Half of the allotment to each state was to be based on the number of children in each state between the ages of five and 17. The other half of the sum made available for allotment to the states each year was to be based on the financial need of each state for carrying out its state plan after taking into consideration the number of children between the ages of five and 17. The effect of the formula was to result in a relatively higher federal subsidy for poorer states. Approximately $2,000,000 or 10 percent of the sum appropriated was to be available to enable the Children's Bureau to administer the Act.

H.R. 1980 was sent to the House Committee on Interstate and
Foreign Commerce where the Chairman of the Committee, Republican Representative Charles A. Wolverton of New Jersey, scheduled hearings on the bill. Major support for the bill came from the National Commission on Children and Youth, American School Health Association, American Federation of Labor, CIO, National Urban League, and the Maternity Center Association. On the other hand, the bill, although thought by many to be part of the Administration Health Care Program, never was endorsed by President Truman and received only token support from the Federal Security Agency and the Children's Bureau.

At about the same time two bills passed by Congress, the National School Lunch Act and National Mental Health Act, greatly strengthened federal support of child health care. In June, 1946, the National School Lunch Act established on a permanent basis the school lunch program through grants to the states to operate non-profit lunch programs. The Department of Agriculture was designated to administer the grant, for which Congress appropriated $75,000,000 for fiscal year 1947. The National Mental Health Act, approved July 3, 1946, included children in its scope. Its stated purpose was to improve mental health of the nation through conducting, assisting and fostering and promoting the coordination of research relating to the cause, diagnosis, and treatment of psychiatric disorders; training of professional personnel in matters relating to mental health; and assisting states in the use of the most effective methods of prevention and treatment of psychiatric disorders. The Public Health Service was given the authority to administer the Act, which included provisions for grants to the states on the basis of plans submitted by the state mental health agencies.
On July 8, 1947, Congress appropriated $7,500,000 to implement the measure.37

In August, 1946, Senator Murray requested that the Children's Bureau along with the Public Health Service and the Social Security Board and several non-governmental public health specialists assist in the re-drafting of the Wagner-Murray bill.38 A committee was formed on September 10, and the group outlined in late October the general procedure that all would follow during the redraft. By January the bill had been drafted and placed in the hands of Senators Murray and Wagner. The introduction of the bill was delayed until May 20, 1947 so as to coincide with the President's message on health. The sponsors made further revisions and sought to obtain wider sponsorship both in the House and the Senate.39

In general the 1947 bill retained all the essential principles of its predecessor, S. 1606. That is, provision was made for a comprehensive nationwide health program through a system of prepaid personal health benefits and through Federal grants-in-aid to the states to enable the expansion of public health and maternal and child health services, the construction of needed hospitals and other medical facilities as well as the promotion of medical research and education.40

However, S. 1320 differed from its predecessor in several ways. Firstly, the grant-in-aid section was liberalized to provide expanded assistance to mothers and children. Further, coverage was extended to include civilian federal employees and all recipients of old-age assistance and aid to the blind and dependent children plus their dependents. Thus virtually the total population was now to be included;
however, the benefits to be provided were the same as in S. 1606. The bill made provisions for a decentralized local administration, with policy determination on the federal level to be vested in a five-man National Health Insurance Board established within the Federal Security Agency. This Board would in turn be advised by a 16 lay member National Advisory Medical Policy Council. Administration of the maternal and child health services was still to be under the Children's Bureau subject to the supervision of the Federal Security Administrator.\(^41\) Special provisions for maternal and child health care in rural areas were provided in the bill (i.e., payment of transportation expense incurred by doctors and nurses, loans for office equipment and child health conferences).

The bill was referred to the Senate Committee on Labor and Public Welfare where hearings were held on the measure. Again the testimony was essentially a repeat of that presented on earlier bills.\(^42\) As with the previous bill S. 1320 was not reported out to Committee; still the issue of a National Health Insurance bill was not yet dead. This time the impetus for revival came from President Truman. The President's State of the Union Message called for enactment of a National Health Program. Mr. Truman urged the adoption of a preventive national health program to include "systematic and wide-spread health and physical education and examinations." "The heart of the program," the President said, "must be national system of payment for medical care based on well tried insurance principles."\(^43\) His proposed health program called for increased federal grants for maternal and child health services and services for crippled children so "that no
community should be without such care." He repeated this recommendation a few days later in his Annual Budget Message and in the President's Economic Report. Then on January 30, 1948, the President sent a letter to Oscar Ewing, Administrator of the Federal Security Agency requesting a comprehensive study of national health needs and then to report back ways to remedy any inadequacies over the next 10 years.

In this connection, the Federal Security Administrator recommended to the President that the fixed ceiling on federal appropriations for maternal and child health program be revised in order that these services reach all children in need. The request followed a series of talks the President and Mr. Ewing had over a period of months in which they decided that a comprehensive analysis of the gap between the nation's health resources and its basic requirements would focus public attention on the importance of further national health legislation.

To help achieve these objectives Mr. Ewing developed plans to call a health conference in the spring of 1948. Because the Federal Security Agency did not have funds to hold such a meeting, a non-profit organization, the National Health Assembly, Inc., was organized to seek contributions from private philanthropic sources. In this manner a total of $45,000,000 was raised. An Executive Committee consisting of 24 persons was selected to organize the meeting. Later, this steering committee was expanded to 39 after the AMA complained that the medical profession lacked adequate representation. With nearly 800 representatives from the medical profession, organized labor, farm groups, consumer organizations, and the National Health Assembly the meeting was held in Washington for four days during the first week in
May of 1948.47

The Assembly was divided into 14 sections, each of which discussed a key health problem. The section on maternal and child health care discussed the unmet medical needs of mothers and children and recommended what the federal and state governments could and should do to correct inadequacies. The maternal and child health subcommittees made six important recommendations to the assembly:

(1) A vigorous program of research in matters related to child life should be established and supported, where necessary, by increased Federal grants.

(2) Federal grants should be increased and extended to provide training of professional personnel responsible for medical care and health supervision of mothers and children.

(3) The Children's Bureau and other appropriate Federal agencies and professional organizations should expand their present work of developing standards of care for maternal and child health.

(4) A positive program of mental health should permeate all services for mothers and children and should be an integral part of all community health programs for children, including those for adolescents.

(5) Services for the rehabilitation of physically and mentally handicapped children should be expanded with increased Federal and State support and should be co-ordinated with the programs of voluntary agencies.

(6) The Federal Security Administrator should call a national conference on school health with representation of the constituent units of the Federal government and of medical public health, dental, nursing, educational and other professional and related voluntary groups, to determine goals.48

Following the Conference, and based largely upon its proceedings, a report to the President was submitted by Mr. Ewing. His report entitled The Nation's Health--A Ten Year Program contained recommendations for a national health program which "would assure for every individual his utmost degree of health ... through providing complete health and medical services to everyone in the Nation ... without regard to his personal economic status."49 Pertaining to
maternal and child health care, Mr. Ewing claimed that 30,000 needless infant and maternal deaths occurred annually because of the lack of proper medical attention due to high cost and the lack of federal funds. In May, 1948, 22,000 crippled children were on the waiting lists of state agencies. The only solution, Ewing argued, would be through a national plan "that will build progressively toward complete medical care, and social, psychological, and health services for children and mothers."50 Ewing then went on to say that financing medical care would be best accomplished for children and mothers by a national system of health insurance, supplemented by special grants for maternal and child health programs. If this system were expanded to reach all the child population by 1960, the cost would be approximately $430,000,000 annually. For this amount all communities and states would be able to provide infant care, well-baby clinics, immunization home visits by nurses, school health services and other special services. Similarly, he stated, if public services for crippled children were extended to all handicapped children by 1960, the cost would be almost $258,000,000 a year. This would provide diagnosis, treatment, hospital and convalescent care for all handicapped children.51

President Truman enthusiastically endorsed Ewing's proposals during the 1948 presidential campaign. This support continued following the Democratic victory that year. On April 26, 1948, a bill (S. 1679) incorporating Ewing's suggestions was introduced in the Senate by Democratic Senator Thomas of Oklahoma for himself and Democratic Senators Murray of Montana, Democratic Wagner of New York, Pepper of Florida, Chavez of New Mexico, Taylor of Idaho, McGarth of Rhode Island,
and Humphrey of Minnesota. The bill was referred to the Senate Committee on Labor and Public Welfare. Similar bills were introduced on the same day in the House by Democratic Representative Dingell of Michigan (H.R. 4312) and Biemiller of Wisconsin (H.R. 4113). These were referred to the Committee on Interstate and Foreign Commerce.

The bill (S. 1679) was presented in seven section or titles with National advisory councils consisting of representatives of organized medicine, government, and the general public established in each section (where applicable) to cooperate with and assist the Surgeon General in the administration of the Act. The six other titles of the bill dealt with federal aid to medical education, establishment of medical research institutions, amendments to extend and liberalize the Hospital Construction Act of 1946, federal grants to assist the states to develop and maintain adequate public health systems and a prepaid personal health program.

Title VI concerned maternal and child health care and would have made grants available to universities, child research institutes, and other similar agencies for research in child development and care with funds up to $16,000,000 a year authorized for this purpose. In addition, other grants were to be made available to states with approved plans for use in developing and improving programs of maternal and child health services and care for crippled children and other physically handicapped children. Twenty five million dollars was authorized for the maternal and child health services for the first year and an additional $25,000,000 for crippled children's services. After the first year, there would not be a ceiling on the amount of
the appropriations. Federal allotments would be made to the states on the basis of child population, relative per capita income, and the extend of child health problems and would cover as much as 75 percent of the total costs of these programs in the lowest income states to 40 percent in the highest incomes.

The purpose of Title VI was clearly stated in the bill:

The services and facilities to be made available to mothers during maternity, infants, children under 18 years, and to crippled children under the Children's Bureau health programs are intended to fill the gaps in the health insurance and other health programs provided by this bill. The bill calls for special attention to rural areas and also the correction of defects and health conditions in children of preschool and school age likely to interfere with their normal development and educational progress. Each state would develop its own state plan for providing all needed health services which must be furnished without regard to economic status and on bases which do not discriminate between children on account of race, creed, color or national origin.55

Hearings were held on the bill in May and June of 1949. More than 20 national organizations, as well as government officials and interested individuals, were invited to attend these hearings and express their opinions concerning the various programs of national health legislation embodied in these bills. Dr. Eliot and Miss Lenroot testified in behalf of the maternal and child health care selection of the bill.56

In general, all the various national organizations supported the expansion of maternal and child health services plus services for crippled children. On the other hand, representatives of the hospital association, insurance companies, farm groups, the Chamber of Commerce, and the various medical societies vigorously opposed Title VII, the health insurance bill. These groups advised against enactment of the
bill on the grounds that the national health insurance bill was "an extreme example of compulsory paternalism, wrong in principle, impossible of practical application, and contrary to our established ways and habits of life and political principles." In the face of this continued opposition to the bill's provisions the Murray Committee, at the conclusion of the hearings, attempted to redraft the bill for resubmission in the next Congress. However, nothing further was heard of the bill. Democratic Representative Dingell of Michigan did submit an identical bill to the next Congress but it too died in committee.

This is not to say that the Congress was unalterably opposed to all health legislation. Of the seven titles of the Omnibus Health bill, the Senate passed four in the form of separate bills. However, of the four, only one, the amendments to the Hospital Construction Act, got beyond the Senate and became law. Nevertheless, the following year, the Senate Democrats united to enact the first major upward revision of Social Security coverage and benefits.

As part of his continuing efforts to secure passage of health insurance, the President, on December 29, 1952, established by Executive Order 10317 the President's Commission on the Health Needs of the Nation to investigate new health needs of the Nation. The President selected as Commission Chairman, Dr. Paul Magnuson, a distinguished surgeon and former chief medical director of the Veterans Administration. Dr. Magnuson appointed the other 14 members. The Commission's work was slated to last one year, with its final report to be released after the November, 1952 elections.

The President's Commission on the Health Needs of the Nation
gathered testimony in regional hearings around the country and on December 18, 1952, the Commission issued its five volume report, Building America's Health. On the question of health care services, the Commission upheld the findings of an earlier survey that a very large number of mothers and children lacked adequate medical care. On the solution to the problem the Commission recommended the continuation and substantial enlargement of grants-in-aid to the states for maternal and child health services and for services to crippled children. The Commission further recommended the creation of a cabinet level Department of Health, Education, and Welfare. Although it recognized that the federal government had a large role to play in the health field, it did not recommend adoption of National Health Insurance.

On January 9, 1953, the President sent Congress the first volume of the Commission's Report along with his last message on the subject of health care. Commending the Commission's work, President Truman conceded that its proposal to give federal grants-in-aid to establish voluntary prepayment plans by the states was probably the best solution to the nation's health needs.

The postwar years witnessed an effort by the President and liberals to enact a comprehensive national health insurance program. Miss Lenroot and Dr. Eliot, representing the Children's Burea, let it be known that they had serious reservations about the Administration's health bills. They realized that a national health program would encounter strong organized opposition in Congress. A defeat might
jeopardize the Bureau's child health program. The Bureau thought a purely maternal and child health proposal (such as the Pepper bill) would have a better chance to pass Congress. Further, Dr. Eliot was highly suspicious of any program which gave the Public Health Service control over a child health program. Nevertheless, the national health insurance movement contributed to child health by keeping alive the issue of health security and undoubtedly contributed to the passage of the 1950 amendments to the Social Security which increased Title V funds.
NOTES

1Summary of S. 1050 may be found in the Congressional Record, 79 Cong., 1 Sess. (1945), LXI, Pt. 4, pp. 4924-4927.


5Congressional Record, 79 Cong., 1 Sess. (1945), LXXXI, Pt. 8, p. 10961; a summary of S. 1606 may be found in Elizabeth W. Wilson, Compulsory Health Insurance (New York, 1947), pp. 19-25 and in the Congressional Record, 79 Cong., 1 Sess. (1945), LXXXXI, Pt. 8, pp. 10790-10795.


7Ibid.

8Ibid., p. 237.

9Ibid.

10Senator Murray, a co-author of the bill, was chairman of this committee thereby assuring at least a hearing for the measure.


12Letter, Truman to Murray, March 20, 1946, ibid.

13Joint memorandum, Louis Schwellenback and Watson B. Miller to the President, March 16, 1946, ibid.

14S. 1318 had nine co-sponsors, including Republican Senator Robert LaFollette, Jr., George Aiken, and Wagner. Although the AMA opposed S. 1318, it was friendly toward Pepper's maternal and child health care bill in 1945. See S. 1318, 79 Cong., 1 Sess. (1945);

15 Joint memorandum, Schwellenback and Miller to the President, March 15, 1946, CBP, NR, RG 2, Box 21.


20 It would be incorrect to state that the AMA response to the Truman health proposal was wholly negative. The AMA supported the Hill-Burton Hospital Survey and Construction Act. The Association also urged the expansion of public health services for the indigent, expansion of preventive medicine programs, and extension of hospitalization and sickness insurance on a voluntary basis; Oliver Garceau, "Organized Medicine Enforces Its 'Party Line,'" *The Public Opinion Quarterly*, IV (1940), 408-428; "The American Medical Association: Power, Purpose and Politics in Organized Medicine," *Yale Law Journal*, LXIII (1954), 937-1022.

21 *Hearings on S. 1606*, pp. 1689-1695.


27 The administrator had to be a physician licensed to practice in one or more states and having experience in actual practice, medical research, teaching or in the Public Health Service.

28 A summary and several analyses of S. 2143 may be found in the *Hearings on S. 1606*, pp. 3064-4986.


31 Hearings on S. 545 and S. 1320: the bill was again introduced by the same sponsors on April 14, 1949, as S. 1581. The text of the bill may be found in the U.S. Senate, Committee on Labor and Public Welfare, Hearings on S. 1106, S. 1456, S. 1581, and S. 1679, 81 Cong., 1 Sess. (1949), pp. 9-29. This time the AMA withheld its support of the bill.


33 The Bureau's major functions were rather limited: it could approve or disapprove of school plans, administer limited demonstration programs, study and recommend the most effective method of providing school health services. The actual day-to-day administration of services was left mainly to the state and local governments and the schools. The National Advisory Committee on School Health Services was to be composed of 12 members appointed by the Federal Security Administration.

34 H.R. 1980.


36 Ibid.


38 Memorandum, Dr. Martha M. Eliot to Watson Miller, December 1, 1946, CBP, NR, RG 363, Box 27, pp. 4-5.

39 Congressional Record, 80 Cong., 1 Sess. (1947), LXXXIII, Pt. 4, p. 5517.

40 S. 1320, 80 Cong., 1 Sess. (1947); a summary of the bill is to be found in the Congressional Record, 80 Cong., 1 Sess. (1947), LXXXIII, Pt. 4, pp. 5517-5522 and also in Wilson, Compulsory Health Insurance, pp. 94-100.

41 The bill also made explicit the guarantees of professional rights of doctors, dentists, and hospitals; it removed the maximum and minimum limits on hospital rates and left it up to the majority of doctors to determine their method of payment. Special provisions for rural areas were provided in the bill. Finally, as in the second Wagner-Murray-Dingell bill of 1945, provision was made for the annual appropriation to the national health insurance fund of an amount equal to three percent of all wages received during the year up to $3,600 per year.

42 Hearings on S. 545 and S. 1320.
See the State of the Union Message, January 7, 1948, Truman, Public Papers, 1948, p. 3.


Hearings on S. 545 and S. 1320, Statement of Marjorie Shearon, pp. 2400-2420; see also J. H. Means, Doctors, People and Government (Boston, 1953), pp. 80, 752.

Ibid.

Ibid.


Ibid., p. 35.

Ibid., pp. 21-22.

Ibid., pp. 157-159.

S. 1679, 81 Cong., 1 Sess. (1949); earlier, on January 5, 1949, Senators Murray and Wagner had introduced a bill (S. 5) quite similar to S. 1320 of 1947. The bill was referred to the Committee on Labor and Public Welfare where it died.

Title I of the bill proposed to increase the number of trained personnel in the field of medicine; Title II authorized the Surgeon General to establish national research institutes to conduct research to discover the cause and treatment of various disease; Title III would have extended the provision of the Hospital Construction and Survey Act of 1946; Title IV authorized grants or loans to medical personnel to move to rural areas; Title V authorized the distribution of federal funds to improve public health; and Title VII provided for prepaid personal health service benefits.

A detailed summary of the bill may be found in the Congressional Record, 81 Cong., 1 Sess. (1949), LXXXV, Pt. 4, pp. 4956-4959.

Ibid.


Ibid., p. 208.

H.R. 54, 82 Cong., 1 Sess. (1951).

These were passed as S. 1453, S. 2591, S. 614, and S. 522; see Congressional Quarterly Almanac, 1949, V, p. 293.
60 Congressional Quarterly Almanac, 1950, VI, pp. 198-99.

61 See statement by the President on Establishing the Commission on the Health Needs of the Nation, December 29, 1951, Truman, Public Papers, 1951, pp. 655-656.


63 United States President's Commission on the Health Needs of the Nation, Building America's Health: A Report to the President (Washington, D.C., 1952), I, pp. 42-44.

64 Ibid., pp. 46-47.

65 Ibid.

CHAPTER VII

SUMMARY AND CONCLUSIONS

On April 9, 1912, President Taft approved the bill creating the Children's Bureau. This marked the beginning of a period of studies of economic and social factors related to infant mortality studies of maternal deaths, studies or maternal and infant care in rural counties, and other investigations. These reports developed support for the first Maternity and Infancy Act in 1921 which authorized federal funds to the states to help support maternal and child health services.

This measure, known as the Sheppard-Towner Act, had a relatively short life, expiring in 1929. But it established the national policy that the people of the United States, through their federal government, shared with the state and local government responsibility for helping to provide child health services. Both the Children's Bureau and the states learned a great deal about administration of grants-in-aid under this program in the 1920's, and laid the ground work for Title V of the Social Security Act, passed in 1935.

The Great Depression led to a broad new concern with social action for children. When the Depression of the 1930's began, the nation had a system of maternal and child health care that was almost entirely locally administered and locally financed. The rapid increase in relief loads in 1930 and 1931 and the decrease in tax revenues
placed an impossible burden on local finances. By 1932, states started to curtail their maternal and child health programs. After a series of special studies, the Children's Bureau discovered malnutrition, including serious protein and vitamin deficiency among children. Infectious and communicable diseases were taking a high toll of infants and preschool children's lives. Studies made by the Bureau and reports from voluntary organizations had also shown that large numbers of crippled children were not receiving medical attention in most states, especially in rural areas. By March, 1933, it had become apparent to the Children's Bureau that the federal government must take direct responsibility for maintaining the state programs. In May, the Federal Emergency Relief Administration was established and given authority to make limited grants to the states maternal and child health programs.

In its struggles against unemployment and poverty, President Franklin D. Roosevelt gave high priority to the needs of children. In June, 1934, the President sent to Congress a special message pointing to the security of the men, women, and children of the nation as the first objective in the task of reconstruction and recovery. Following this message he set up by executive order a special Cabinet Committee on Economic Security to make recommendations on a comprehensive program relating to old age security, unemployment health insurance, and maternal and child health. The Cabinet Committee was assisted by a technical board and a number of advisory groups. A report of the Committee was transmitted to Congress on January 17, 1935, together with a bill carrying out its recommendations.

The passage of the Social Security Act, which became law on
August 14, 1935, marked a new stage in the acceptance by the federal government of responsibility for welfare of mothers and children. Title V grants in the nature of formula based support were for basic preventive maternal and child health services and for the location, diagnosis, and treatment of children with crippling or potentially crippling conditions. Although some states and many localities had health programs by the beginning of the thirties, many areas of the country, particularly rural sections, had only partial services and many were without any organized health protection.

In 1935, before the passage of the Social Security Act, only 23 state health departments had programs of maternal and child health services. Some of these were extremely limited in scope; for example, only 13 states had any form of service to crippled children, and no state or local health agency had sufficient resources to meet fully the health needs of all its children. By 1948, all the states and territories had divisions of maternal and child health and crippled children's services. To stimulate state and local child health services and crippled children's services and to provide a financial basis for their extension, the 1935 Social Security Act authorized federal grants of $3,800,000 for maternal and child health services and $2,850,000 for services to crippled children.

At first, the maternal and child health programs were largely devoted to pre- and postnatal clinics and child health clinics and to training of professional personnel. But in 1937, the Bureau's advisory committees recommended that the program be enlarged to provide medical and hospital care of mothers during labor and delivery. Again in
1939, the Bureau urged the expansion of maternal and child health and crippled children services.

The effort to expand maternal and child health care came at a time when organized medicine was in an active campaign against the first Wagner National Health bill; a national medical care program, which was based upon the proposals of an Interdepartmental Committee. Despite an intensive campaign, Congress amended the Social Security Act that year to increase the maximum for grants to the states for maternal and child health, and made objective standards for merit systems applicable to approval of state plans for maternal and child health. Congress made additional funds available for crippled children's services as a new "Fund B" with the understanding that part would be used to assist states in developing programs for the care of children with rheumatic heart disease.

During World War II a program of emergency maternity and infant care for dependents of servicemen in the lower grades of the Armed Forces (known as EMIC) was carried out through federal grants to the states provided under successive annual appropriation acts. Under the supervision of the Children's Bureau, some 1,250,000 mothers received maternity care and 230,000 infants received medical services under this program before its termination. Emergency Maternity and Infant Care program (EMIC) was entirely supported by general tax funds--no matching funds and no means test. The program enabled state health departments to make major progress in licensing and upgrading hospital maternity care and further aided hospitals to improve standards by establishing a basis of payment related to the cost-of-care--a principle later
adopted by other federal agencies and by the Blue Cross Insurance plans.

Some 48,000 doctors and 5,000 hospitals had cooperated in giving care. During its years of operation, the EMIC program was the most extensive single public medical care program ever undertaken in America. Emergency Maternity and Infant Care program was a forerunner of the Dependents of Military Personnel Act (1956) administered by the Departments of Defense, which covers most of the cost of maternity care and of hospitalization and limited outpatient services in civilian facilities for the wives and children of members of the armed forces.2

During the World War II, the Children's Bureau emphasized again the need to solve the problems of neonatal mortality and undertook a study of neonatal deaths which brought to national attention the importance of concentrating efforts on the care of premature infants. To develop meaningful reports of the number of children in need of medical care, the Bureau continued to sponsor annual collection and publication of statistical reports. These covered such topics as infant and maternal mortality, crippled children, and other categories.

After the war, the staff of the Children's Bureau attempted to encourage and stimulate research relating to child health care, not only in state agencies, but also in institutions of higher learning and teaching hospitals. Federal grants to state health and crippled children agencies were utilized for special studies, which often resulted in significant scientific discoveries. Despite the Bureau's efforts to encourage research relating to child health, there were periods during which its responsibilities in extending services for mothers and
children had to take precedence over its promotion of child health research. However the establishment in Title V of specific authorization for program-related research in child health in amendments enacted in 1963 and 1965 made possible federally financed research projects.

Title V of the Social Security Act was again amended in August, 1946, to provide increased appropriations for maternal and child health services and services for crippled children. As amended, Title V authorized an annual appropriation of $11,000,000 for maternal and child health services; $7,500,000 for services for crippled children.

Title V of the Social Security Act and EMIC aided states to establish divisions or bureaus of maternal and child health within the public health departments. Through federal grants-in-aid, these had been able to extend services to local areas, especially rural areas. States differed considerably in the emphasis given to various services, but, most commonly, they supplied maternity clinics, prenatal classes, instruction and supervision for untrained midwives, hospital maternity care and premature infant care, public health nursing visits to mothers and children, and well-baby conferences. These services played a major role in preventing mortality and in promoting the health of mothers and children. The 1946 Children's Bureau annual report indicated a drastic reduction in the maternal mortality rate since the introduction of the federal grant-in-aid support. In 1935, the year the Social Security Act was passed, for every 10,000 live births, 58 mothers lost their lives; by 1946, this figure was down to 16. In 1935, for every 10,000 live births, 560 infants under one year of age
lost their lives; by 1946 this rate had been cut to 340.\textsuperscript{3}

After the war, federally funded maternal and child and crippled children programs continued to expand and develop. That development can be measured in total dollars expended from $2,500,000 in 1935-1936 to more than $26,000,000 in 1952-1953. It can be measured indirectly in the decline in maternal and infant mortality rates. The infant mortality rate for the nation had been reduced from 100 deaths per 1,000 live births in 1915 to 29 in 1953, and maternal mortality declined from 58 deaths per 10,000 in 1939 to 7 deaths per 10,000 in 1953.\textsuperscript{4} And it can be assessed in terms of the broadening scope of the crippled childrens program from its early emphasis on orthopedic conditions to its attempt to prevent or ameliorate any disabling condition.

During the first 15 years of the Social Security Act there had been a marked decrease in the mortality rates. The period of greatest reduction occurred before World War II and the immediate postwar period. Behind this remarkable progress have been three phenomena: widespread adoption of sanitary measures by local governments; new medical breakthroughs; and the growth of federal services.

One important stimulus to the promotion of child health care came from the rapid pace of advances in medicine, and especially in pediatrics and obstetrics, and in medical education. A series of fundamental discoveries in medicine of the last 50 years opened new approaches to the prevention and control of childhood diseases. New forms of surgery for congenital defects, the use in food and drugs for the prevention and treatment of rickets and pellagra, the introduction of vaccines that erased diptheria and pertussis, the prevention of
congenital syphilis through premarital and prenatal blood testing and treatment, earlier and more effective rehabilitation for the crippled—all these have saved the lives of many children.

A second stimulus came from the rapid spread of public health at the state and local level. State and local public health departments promoted the public protection of water and milk supplies and the sanitary disposal of human waste which reduced infant deaths from infectious diarrhea, typhoid, and tuberculosis.

Finally the development of a federal funded maternal care program—first with Title V of the Social Security Act and later with the Emergency Maternal and Infant Care program—provided the governmental framework which state and local child health departments could join to form programs which were quite new to public health. The part the Children's Bureau has played in administering the two grant-administering programs has been crucial to the success of these services.

The principle of federal grants to states under the Social Security Act made possible a greater extension of maternal and child and crippled children services by the states. The grants have provided money with which the states have been able to start needed medical services for children and families with special problems. The federal grants have made it possible for states to develop the skilled staffs required for these special services by providing educational leave grants, fellowships, and grants for professional training institutes, refresher courses, and training for specialized staff required for expanded services. They have made possible demonstrations and research
projects that have led to better quality or new services. Under the leadership of the Children's Bureau and the state departments of health, a network of public services for mothers and children have been established as an integral part of the public health program.

The federal grants have drawn out additional state and local funds; federal funds have always represented a relatively small proportion of the total amounts spent for maternal and child health services and crippled children programs. For example, in 1940 the state and local maternal and child health programs were financed by a budget of about $11,500,000; of this $6,000,000 were from state and local funds; $5,500,000 from federal. For 1954, the total amount budgeted was $40,500,000. The states put up more than $30,000,000, the federal government $10,500,000. In 1940, the federal government contributed to a combined budget 48 percent of $11,500,000; in 1954, the federal contribution was only 26 percent of $40,500,000.5

Although the federal grants to states were small, much was accomplished in the first 15 years of Title V—new services initiated, old ones expanded, reduction of maternal and infant mortality rates. More important Title V demonstrated the feasibility of providing health services for mothers and children on a national basis. More importantly, the early federal grants also paved the way for extending the child health and crippled services in the 1950's and 1960's.

In the early 1950's, the Children's Bureau gave special emphasis to the development of programs for the mentally retarded child. The Bureau activities centered on the perinatal causes of mental retardation, the need to improve the quality of maternity care, the
care of newborn infants, and the prevention of premature birth. Attention was also given to improving community services and facilities for assisting parents in the care of retarded infants and children. The Children's Bureau also began to pioneer in making grants from maternal and child health funds for community services for mentally retarded children. In 1954, $1,000,000 of the appropriation for maternal and child health was earmarked for mental health. In 1957, Congress designated an additional $1,000,000 of the maternal and child fund for special projects for mentally retarded children. In 1962, a request of President Kennedy, a special task force on mental retardation brought together experts in the medical profession to study the relationship of complications of childbirth to mental retardation. In 1963, grants for comprehensive maternity and infant care projects to reduce complications of childbirth were authorized by Congress.6

Gradually during the 1950's the ceilings placed on amounts authorized for appropriations increased until in 1958 the amount for maternal and child health reached $21,500,000 and that for crippled children's services $20,000,000. Furthermore, the Bureau increased its demonstration projects for the care of premature infants and encouraged states to give greater attention to prenatal care for mothers with complications of pregnancy. At the same time the Bureau encouraged the states to extend their crippled children's programs to include a variety of disabilities in addition to orthopedic defects.

In carrying out its administrative functions the Children's Bureau directed its attention toward stimulating improvement in the quality of care, experimentation by the states in new programs and
methods, and increased use of multidisciplinary groups of professional personnel; and toward focusing the states attention on the child as a person rather than only on the part affected by illness. This emphasis on quality was the controlling force within the Bureau.

New infant care projects were added to Title V of the Social Security Act by the Maternal and Child Health and Mental Retardation Amendments of 1963. The Amendment authorized the Children's Bureau to provide funds on a project basis to assist state and local health departments in meeting up to 75 percent of the costs of programs of comprehensive maternity and infant care for low-income families. These medical care programs made it possible to increase the number of prenatal and post-natal clinics; brought the prenatal and postpartum clinics close to the population served, relieved overcrowding in tax-supported clinics by paying for care in voluntary hospitals; expanded services for mentally retarded children and pay for hospital care of premature infants and other infants needing special attention. Another part of the amendments to Title V provided a new program of grants to public health agencies for programs to supply "complete maternity services for women with inadequate income who have, or are likely to develop, conditions hazardous to themselves or their babies." New research grants also were given for studies related to maternal and child health and crippled children services.

The Social Security Act Amendments of 1965 provided new opportunities for expanded and improved MCH and Crippled Children services—the provision for increased authorizations in the established children's program, the special projects grants for comprehensive treatment of
children in low-income areas, as well as the Title XIX provision for medically indigent children. For the first time, the Children's Bureau could make grants to medical schools and teaching hospitals to pay up to 75 percent of the cost of projects of a comprehensive nature for health services and medical care for children and youth of low-income families. Sections 201 and 202 of Title II of the Act authorized increased appropriations for maternal and child health and crippled children programs, and section 203 authorized the appropriation of $17,500,000 per year for grants for the training of professional personnel to care for crippled, mentally retarded and multiply handicapped children. Section 205 authorizes grants of $50,000,00 per year to promote the health of children and youth of pre-school and school age, particularly in areas with concentration of low income families.

The 1965 Amendments to Title V imposed a requirement that each state plan for maternal and infant care and crippled children's services must, in order that the state may receive payments, make a satisfactory showing that the state is extending these services with a view to making them available by July 1, 1975, to all parts of the state.

During 1967, a number of changes were made in Title V of the Social Security Act. Three new types of medical care project grants were authorized: Infant Care, Family Planning, and Dental Care projects. At the same time, the structure of the authorizing sections in the Title was modified. Instead of having separate authorizations for each section, with one for each formula grant and one for each special project, all authorizations were brought into one package and
a ceiling set increasing the authorization to a maximum of $350,000,000 each year. In order to distribute the appropriation among the sections, the 1967 Amendments specify that 50 percent of the annual appropriation was to be for formula grants, which have a rural emphasis (maternal and child health and crippled children); 40 percent for project grants (maternal and child health, etc.); and 10 percent for research and training.\(^8\)

Grants for projects providing dental care for children of school and preschool age in low-income areas were authorized by the 1967 Social Security Act. Training grants are authorized under the 1967 Social Security Amendments to public or non-profit private institutions of higher learning for training personnel for health care and related services for mothers and children, particularly retarded and multiple handicapped children.

In August, 1969, the Children's Bureau was transferred to the Office of Child Development—a new agency in the Office of the Secretary of Health, Education, and Welfare—where it continues to carry out the provisions of the Congressional Act of 1912, to investigate and report on all matters pertaining to the welfare of children, to make grants for research, and to act as a spokesman on behalf of children. Health programs previously administered by the Children's Bureau were transferred to the Health Services and Mental Health Administration.\(^9\)

For fiscal year 1969, the last year the Children's Bureau administered Title V, Congress appropriated $50,000,000 for maternal and child health service, $57,000,000 for crippled children's services,
$48,000,000 for maternal and infant care projects, $39,000,000 for projects for health of school and preschool age children, $9,000,000 for training of personnel for health care and services to mothers and children, and $6,200,000 for research projects relating to maternal and child health and crippled children's services--no federal funds were made available for dental health care.

The maternal and child health and crippled children's programs have expanded and developed since passage of the Social Security Act in 1935. The development can be measured in total dollars expended, from $2,500,000 in 1935-1936 to more than $250,000,000 in 1969-1970, when Title V functions of Children's Bureau were transferred to HSMS. The program can be measured indirectly in the decline in maternal and infant mortality and it can be assessed in terms of the broadening scope of the crippled children program.

During the years in which the Children's Bureau administered Title V, the degree to which its purposes were fulfilled presented an impressive record. The Bureau showed that a federal grant-in-aid program could successfully reduce the maternal and infant mortality rates of the country. As importantly, however, the administration of Title V by the Bureau served to modify the American tradition of legislative refusal to permit the expenditure of federal funds for welfare purposes.
NOTES


APPENDIX A

ACT ESTABLISHING THE CHILDREN'S BUREAU

[U.S. Statutes, XXV, Part I, pp. 79-80]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That there shall be established in the Department of Commerce and Labor a bureau to be known as the Children's Bureau.

Sec. 2. That the said Bureau shall be under the direction of a chief, to be appointed by the President, by and with the advice and consent of the Senate.

The said Bureau shall investigate and report upon all matters pertaining to the welfare of children and child life among all classes of our people, and shall especially investigate the questions of infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, legislation affecting children in the several States and Territories. ***
APPENDIX B

TEXT OF TITLE V OF THE SOCIAL SECURITY ACT

[U.S. Statutes, IL, Part I, pp. 620-648]

Part 1--Maternal and Child Health Services

APPROPRIATION

SECTION 501. For the purpose of enabling each State to extend and improve, as far as practicable under the conditions in such State, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $3,800,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

ALLOTMENTS TO STATES

SEC. 502. (a) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and such part of $1,800,000 as he finds that the number of live births in such State bore to the total number of live births in the United States, in the latest calendar year for which the Bureau of the Census has available statistics.

(b) Out of the sums appropriated pursuant to section 501 for each fiscal year the Secretary of Labor shall allot to the States $980,000 (in addition to the allotments made under subsection (a), according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of live births in such State.

(c) The amount of any allotment to a State under subsection (a) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 504 until the end of the second succeeding fiscal year. No payment to a State under section 504 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.
APPROVAL OF STATE PLANS

SEC. 503. (a) A State plan for maternal and child-health services must (1) provide for financial participation by the State; (2) provide for the administration of the plan by the State health agency or the supervision of the administration of the plan by the State health agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State health agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to assure the correctness and verification of such reports; (5) provide for the extension and improvement of local maternal and child-health services administered by local child-health units; (6) provide for cooperation with medical, nursing, and welfare groups and organizations; and (7) provide for the development of demonstration services in needy areas and among groups in special need.

(b) The Chief of the Children's Bureau shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the Secretary of Labor and the State health agency of his approval.

ALLOTMENTS TO STATES

SEC. 512. (a) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State $20,000, and the remainder to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to in section 511 and the cost of furnishing such services to them.

(b) The amount of any allotment to a State under subsection (a) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

APPROVAL OF STATE PLANS

SEC. 513. (a) A State plan for services for crippled children must (1) provide for financial participation by the State; (2) provide for the administration of the plan by a State agency or the supervision of the administration of the plan by a State agency; (3) provide such methods of administration (other than those relating to selection, tenure of office, and compensation of personnel) as are necessary for the efficient operation of the plan; (4) provide that the State agency will make such reports, in such form and containing such information, as the Secretary of Labor may from time to time require, and comply with such provisions as he may from time to time find necessary to
assure the correctness and verification of such reports; (5) provide
for carrying out the purposes specified in section 511; and (6) provide
for cooperation with medical, health, nursing, and welfare groups and
organizations and with any agency in such State charged with administer­ing
State laws providing for vocational rehabilitation of physically
handicapped children.

(b) The Chief of the Children's Bureau shall approve any plan which
fulfills the conditions specified in subsection (a) and shall there­
upon notify the Secretary of Labor and the State agency of his approval.

PAYMENT TO STATES

SEC. 514. (a) From the sums appropriated therefor and the allotments
available under section 512, the Secretary of the Treasury shall pay to
each State which has an approved plan for services for crippled chil­
dren, for each quarter, beginning with the quarter commencing July 1,
1935, an amount, which shall be used exclusively for carrying out the
State plan, equal to one-half of the total sum expended during such
quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as
follows:

(1) The Secretary of Labor shall, prior to the beginning of each
quarter, estimate the amount to be paid to the State for such quarter
under the provisions of subsection (a), such estimate to be based on
(A) a report filed by the State containing its estimate of the total
sum to be expended in such quarter in accordance with the provisions
of such subsection and stating the amount appropriated or made avail­
able by the State and its political subdivisions for such expendi­
tures in such quarter, and if such amount is less than one-half of the
total sum of such estimated expenditures, the source or sources from
which the difference is expected to be derived, and (B) such inves­
tigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estima­
ted by him to the Secretary of the Treasury, reduced or increased, as
the case may be, by any sum by which the Secretary of Labor finds
that his estimate for any prior quarter was greater or less than the
amount which should have been paid to the State for such quarter,
except to the extent that such sum has been applied to make the
amount certified for any prior quarter greater or less than the
amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the
Division of Disbursement of the Treasury Department and prior to
audit or settlement by the General Accounting Office, pay to the
State, at the time or times fixed by the Secretary of Labor, the
amount so certified.

PAYMENT TO STATES

SEC. 504. (a) From the sums appropriated therefor and the allotments
available under section 502(a), the Secretary of the Treasury shall pay
to each State which has an approved plan for maternal and child-health
services, for each quarter, beginning with the quarter commencing July 1, 1935, an amount, which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan.

(b) The method of computing and paying such amounts shall be as follows:

(1) The Secretary of Labor shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than one-half of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary.

(2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased, as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter.

(3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

(c) The Secretary of Labor shall from time to time certify to the Secretary of the Treasury the amount to be paid to the States from the allotments available under section 502 (b), and the Secretary of the Treasury shall, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, make payments of such amounts from such allotments at the time or times specified by the Secretary of Labor.

OPERATION OF STATE PLANS

SEC. 505. In the case of any State plan for maternal and child-health services which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 503 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.
Part 2—Services for Crippled Children

APPROPRIATION

SEC. 511. For the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in such State, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare, for children who are crippled or who are suffering from conditions which lead to crippling, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of $2,850,000. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Chief of the Children's Bureau, State plans for such services.

OPERATION OF STATE PLANS

SEC. 515. In the case of any State plan for services for crippled children which has been approved by the Chief of the Children's Bureau, if the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds that in the administration of the plan there is a failure to comply substantially with any provision required by section 513 to be included in the plan, he shall notify such State agency that further payments will not be made to the State until he is satisfied that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.
APPENDIX C

TRANSFER OF THE CHILDREN'S BUREAU FROM THE
DEPARTMENT OF LABOR TO THE FEDERAL
SECURITY AGENCY
(under Reorganization Act of 1945)

SEC. 1. Children's Bureau—(a) The Children's Bureau in the Depart­
ment of Labor, exclusive of its Industrial Division, is transferred to
the Federal Security Agency. All functions of the Children's Bureau
and of the Chief of the Children's Bureau except those transferred by
subsection (b) of this section, all functions of the Secretary of Labor
under title V of the Social Security Act *** as amended and all other
functions of the Secretary of Labor relating to the foregoing functions
are transferred to the Federal Security Administrator and shall be
performed by him or under his direction and control by such officers
and employees of the Federal Security Agency as he shall designate,
except that the functions authorized by section 2 of the act of April
9, 1912, *** and such other functions of the Federal Security Agency as
the Administrator may designate, shall be administered, under his
direction and control, through the Children's Bureau.

(b) The functions of the Children's Bureau and of the Chief of the
Children's Bureau under the Fair Labor Standards Act of 1938 (52 Stat.
1060), as amended, are transferred to the Secretary of Labor and shall
be performed under his direction and control by such officers and
employees of the Department of Labor as he shall designate ***.

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APPENDIX D

ACT TRANSFERRING THE FUNCTIONS OF THE FEDERAL SECURITY
AGENCY TO THE DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

[U.S. Statutes, LXVII, Part I, pp. 632-634]

Resolved by the Senate and House of Representatives of the United States of American in Congress assembled, That the provisions of Reorganization Plan Numbered 1 of 1953, submitted to the Congress on March 12, 1953, shall take effect ten days after the date of the enactment of this joint resolution, and its approval by the President ***.

REORGANIZATION PLAN NO. 1 OF 1953

SEC. 1. Creation of Department; Secretary—There is hereby established an executive department, which shall be known as the Department of Health, Education, and Welfare *** There shall be at the head of the Department a Secretary of Health, Education, and Welfare ***.

SEC. 5. Transfers to the Department—All functions of the Federal Security Administrator are hereby transferred to the Secretary. All agencies of the Federal Security Agency, together with their respective functions *** are hereby transferred to the Department ***.
INFANT MORTALITY, UNITED STATES, 1915-1962

Deaths per 1,000
live births

100

Infant (under 1 year)

Neonatal (under 28 days)

1915 1930 1945 1960
MATERNAL MORTALITY, UNITED STATES, 1915-1962

Deaths per 10,000 live births

GROWTH IN MATERNAL AND CHILD-HEALTH SERVICES, 1937-1953

- preschool children attending well-child conferences
- infants attending well-child conferences
- expectant mothers attending prenatal clinics

Preschool children attendance in thousands:
- 300

Infants attendance in thousands:
- 200
- 100

Expectant mothers attendance in thousands:
- 100

BIBLIOGRAPHY

Manuscripts

Records of the Children's Bureau. Federal Records Center, Suitland, Maryland.


Records of the Social Security Administration. National Archives, Washington, D.C.

Government Documents


Hearings on H.R. 2366. 67 Cong., 1 Sess., 1921.


Hearings on the First Deficiency Appropriation Bill for 1943. 78 Cong., 1 Sess., 1943.

Hearings on H.R. 2935. 78 Cong., 1 Sess., 1943.

Hearings on H.R. 159. 78 Cong., 1 Sess., 1943.

Hearings on H.R. 4899. 78 Cong., 2 Sess., 1944.


Hearings on H.R. 230. 79 Cong., 1 Sess., 1945.

Hearings on Department of Labor Appropriation Bill for 1946. 79 Cong., 1 Sess., 1945.


Social Security Amendments. Document No. 120. 76 Cong., 1 Sess., 1939.


Senate. Hearings on S. 1130. 74 Cong., 1 Sess., 1935.


Senate. Hearings on S. 1620. 76 Cong., 1 Sess., 1939.

Hearings on S. 904. 79 Cong., 1 Sess., 1945.

Senate. Hearings on S. 1606. 79 Cong., 1 Sess., 1946.

Senate. Hearings on S. 545 and S. 1320. 80 Cong., 1 Sess., 1948.


U.S. Statutes at Large, 1912-1969.


Periodicals


Becker, Harry J. "Much Has Been Learned So Far." Hospitals, XVIII (October 1944), 38-42.


Britten, Rollo H. "The National Health Survey." Public Health Reports, LV (November 1940), 2199-2224.


"Can Motherhood be Made Safe?" Public Health Nursing, XXX (May 1938), 269-270.


"Child Health Recovery Program." Child Health Bulletin, X (February 1934), 40-44.


"EMIC." Journal of the American Medical Association, CXXIV (January 1944), 241-246.


Freeman, R. G. "Pasteur Milk as Supplied to the Poor by the Straus Milk Depot of New York." Medical Record, XLVI (1894), 133-134.


"Health under the Social Security Act." Social Service Review, X (March 1936), 12-22.


Laux, J. D. "EMIC." Journal of the American Medical Association, CXXIV (April 1944), 1057.


_______, "Relation of the Social Security Act to Present Day Problems of Childhood." Childhood Education, XII (February 1935), 53-56.

Lesser, Arthur J. "Closing the Gaps in the Nation's Health Services for Mothers and Children." Bulletin of the New York Academy of Medicine, XIL (December 1965), 1248-1253.


McNeile, Lyle G. "Maternal and Child Welfare: It's Progress under the Social Security Act." California and Western Medicine, III (October 1937), 240-245.


"Medical Services for Families of Service Men." The Journal of the Indiana State Medical Association, XXXVI (June 1943), 361-362.


Books


Berry, G. H. *Idleness and the Health of a Neighborhood*. New York: The New York Association for Improving the Condition of the Poor, 1933.


