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R-61

HEALTH AND SOCIAL SECURITY FOR THE AMERICAN PEOPLE

A Report to

PRESIDENT-ELECT JOHN F. KENNEDY

by the

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January 10, 1961

Introduction

The Task Force on Health and Social Security was appointed by President-Elect Kennedy to review from among the most pressing and significant health and welfare proposals those which should have priority in the initial phase of the new Administration.

The recommendations of the task force consist of the following proposals:

A. MEDICAL AND HEALTH PROGRAMS

1. Medical Care for the Aged and Other Social Security Beneficiaries
2. Medical Education and Medical Manpower
3. Medical Research
4. Medical Care Facilities
5. Establishment of a National Academy of Health
6. Creation of a National Institute of Child Health

B. SERVICES FOR FAMILIES, CHILDREN AND OLDER PERSONS

7. Assistance to Children of an Unemployed Parent
8. Preparation of a Family and Child Welfare Services Plan
9. Strengthening and Streamlining Administrative Organization

C. UNEMPLOYMENT INSURANCE AND THE SOCIAL SECURITY PROGRAMS

10. Improvements in Unemployment Insurance
11. Improvements in Old-Age, Survivors and Disability Insurance
12. Improvements in Public Welfare

The task force has had available to it the public recommendations of various groups, and a substantial body of data, including the information and conclusions in the following official reports which have been of inestimable value to it in making its recommendations:

1. Federal Support of Medical Research: Report of the Committee of Consultants on Medical Research to the Senate Committee on Appropriations (The Jones Report), 1960.

2. Physicians for a Growing America: Report of the Surgeon's General's Consultant Group on Medical Education (The Bane Report), 1959.

3. The Advancement of Medical Research and Education Through the Department of Health, Education and Welfare (The Bayne-Jones Report), 1958.

4. Hospitalization Insurance for OASDI Beneficiaries: Report Submitted to the Committee on Ways and Means by the Secretary of Health, Education, and Welfare (The Flemming Report), 1959.

5. Report of the Advisory Council on Public Assistance (The Mitchell Report), 1960.

6. Report of the Advisory Council on Child Welfare Services (The Kidneigh Report), 1959.

7. The Condition of American Nursing Homes, A Study by the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare (The McNamara Committee), 1960.

8. Report of the Special Committee on Unemployment Problems, 86th Congress, 2nd Session, Report No.1206 (The Eugene Mc Carthy Committee), 1960.

The Task Force urges the favorable consideration of the proposals discussed in this report.

HEALTH AND SOCIAL SECURITY FOR THE AMERICAN PEOPLE

An adequate standard of health and welfare for all of the American people requires the leadership and support of the Federal government.

The American people have recognized and accepted the responsibility of the Federal Government to help improve health and welfare services. This principle requires effective implementation in 1961.

The Task Force has confined itself to the most immediate necessities for Federal action and does not present its recommendations as a complete program for health and welfare. We have been deeply conscious of the need for selectivity in the light of the cost of such proposals in relation to the other imperative and immediate fiscal and administrative demands upon the Federal government. We have also been concerned about the most effective and practical methods of meeting these costs and are proposing fiscally sound methods to achieve the desired objectives. Our proposals place a major reliance on the self-financing methods of contributory social insurance and repayable loans supplemented only where clearly necessary by funds from the general revenues.

A. MEDICAL AND HEALTH PROGRAMS

The United States can be proud of its remarkable and continually improving health and medical care personnel, facilities and programs. Yet, in our country there are still significant medical care needs which can and should be met and which can only be met if the Federal government takes a more vigorous role in the financing, organization and stimulation of health and medical care.

1. MEDICAL CARE FOR THE AGED AND OTHER SOCIAL SECURITY BENEFICIARIES

The only sound and practical way of meeting the health needs of most

older people is through the contributory social security system. This system permits people to contribute during their working years to the relatively heavy costs of medical care in their later years. It assures full freedom in the choice of qualified physicians and medical facilities and uses the tried and tested insurance method of payment for hospital and medical care with which millions of Americans of working age are familiar through Blue Cross and other private insurance. The same principles apply to widows, surviving children, and permanently disabled persons who are receiving social security payments.

Scope of Benefits

Hospital and related institutional costs place such an impossibly heavy financial burden on these groups of people that these costs should receive the major emphasis in any program. Moreover, the hospital is increasingly the center of health activities in the community -- as it should be. But at the same time the plan should include incentives to use appropriate alternative personnel and facilities of a less costly and non-institutional character.

The essential benefits in any such program at this time should include:

(1) inpatient hospital services,

(2) out-patient hospital diagnostic services,

(3) skilled nursing home services,

(4) home health services.

The inpatient and out-patient hospital services would be effective approximately one year after enactment of the legislation. To give time to make necessary arrangements skilled nursing services and home health services would be available two years after enactment. By including in the legislation provisions which would give an individual two units of nursing service and

three units of home health services for one day of hospital service there would be an incentive to use these out-of-hospital services.

There are those who contend that there are not sufficient personnel and facilities to make it feasible to put this program into effect at this time. Certainly, incentives should be created for the establishment of additional personnel and facilities as recommended subsequently in this report. But this should not be a reason for delay in instituting an insurance program. One of the most important ways in which personnel and facilities are stimulated and more equitably distributed is by providing a mechanism for paying for such services. Assurance of continued financial support for services is one of the key elements in the development of personnel and facilities.

Administration

The legislation would clearly provide that:

(1) In no way are any of the provisions intended to socialize medical care;

(2) Free choice of physician, hospital, nursing home and nurse are assured to every individual by law;

(3) There would be no supervision or control over the practice of medicine, or over the administration of any hospital or facility;

(4) Providers of service would be paid on the basis of reasonable cost as may be mutually agreed to by the provider of service and the Secretary of Health, Education, and Welfare and any agreement could be terminated upon notice by either party;

(5) Any provider of service could designate an agent to negotiate arrangements with the Federal government;

(6) A national advisory council would be established consisting of outstanding persons in the hospital and health fields. The

Council would be consulted in the development of policy and regulations in the administration of the program.

(7) General definitions for participating hospitals, skilled nursing homes, and agencies providing home health services would be indicated in the statute. The Secretary should be authorized to use appropriate State agencies in determining whether a particular hospital, skilled nursing home or home health agency meets the definition for participation.

Financing

The cost of the medical care benefits should be fully financed by future contributions to the insurance system. The costs of various alternatives are shown in Table 1.

A plan which involved initial contributions of 0.5 per cent of taxable payrolls (one-quarter per cent each on employers and employees) during the first five to ten years and then stepped up to about 0.8 per cent (0.4 per cent on each party) would permit the development of a reasonably adequate benefit program consistent with a consideration of the financial effect on participants and the economy.

Table 1

ESTIMATES OF EARLY YEAR[1] AND LEVEL PREMIUM COST[2] FOR THE ANDERSON-KENNEDY AMENDMENT OF 1960 AND VARIOUS SUGGESTED MODIFICATIONS

as a Per cent of Taxable Payrolls

Specifications of Medical Insurance Plan	Early Year Costs with taxable earnings base of --		Level Premium Costs with taxable earnings base of --	
	$4800	$7200	$4800	$7200
A. Anderson-Kennedy Amendment[3]	0.39	0.34	0.58	0.53
B. Anderson-Kennedy Amendment with elimination of $75 deductible	0.47	0.41	0.72	0.65
C. Anderson-Kennedy Amendment in (A) plus Eligibility at age 65/62	0.53	0.46	0.73	0.66
D. Anderson-Kennedy Amendment in (A) plus Eligibility at age 65/62 and elimination of $75 deductible	0.64	0.56	0.91	0.83
E. Anderson-Kennedy Amendment in (C) plus survivors and disabled beneficiaries	0.55	0.48	0.76	0.69
F. Anderson-Kennedy Amendment in (D) plus survivors and disabled beneficiaries	0.66	0.58	0.94	0.86

Source: Chief Actuary, Social Security Administration, January 3, 1961. These estimates may be subject to minor changes. The estimates differ slightly from those used in mid-1960 due in part to the 1960 changes in the OASDI program and some revisions in the assumptions.

[1] Early year costs are defined as the average of the costs for the years between 1962-1970.

[2] Level Premium cost is the average cost for the long-run.

[3] As offered in the Senate, August 1960. The amendment included insured persons age 68 and over.

The contributory insurance system should be authorized to provide funds for:

(1) Community demonstration projects relating to the development of personnel and facilities to meet the health needs of individuals under the program;

(2) Community studies on the ways to increase the adequacy of personnel and facilities;

(3) Consultative services to the States looking toward methods for helping develop adequate facilities within each State, and bringing their services and their facilities up to needed levels of performance.

To the extent that it is not immediately feasible to make the new program initially comprehensive, the Secretary should make recommendations to the President and the Congress on any unmet needs and, through the Public Health Service and other agencies, to encourage the development of economical and appropriate forms of health care which are a constructive alternative to hospital care.

Coverage of aged not insured under social security

Many of the noninsured aged are already protected under other existing programs. Thus, under recently enacted provisions of law Federal civil service annuitants now have medical care protection. So, too do veterans who are eligible for veterans' pension or compensation. Accompanying legislation can be enacted by Congress so that railroad retirement annuitants will have benefits no less favorable than social security beneficiaries. The small remaining group can be taken care of by the States under public assistance. Enactment of the medical insurance plan will relieve the States of a substantial long-run cost involving probably more than $250 million annually.

If experience demonstrates that the existing financial or other plan provisions of the Federal public assistance legislation are not adequate to meet this residual need, then further Federal legislation can and should be enacted as the need is demonstrated.

* * *

The benefit, financing, administrative and other policy implications and alternatives in this program have been discussed with the Commissioner of Social Security. The details of a sound and workable plan are in the process of completion and are available from the Commissioner for the consideration and appropriate action of the Secretary-designate.

2. MEDICAL EDUCATION AND MEDICAL MANPOWER

In order to achieve the Administration's objective with respect to medical care for the aged as well as the health of the population as a whole, we regard it as essential that the Federal government take prompt action to increase the supply of medical and other health personnel including physicians, dentists, nurses, public health personnel, and social workers. We are especially concerned that according to the Bane report to the Surgeon General 40 per cent of all medical students come from the 8 per cent of the families with the highest incomes.

A program for medical education and medical manpower should consist of the following inter-dependent components which are listed in the order of urgency:

1. Federal support for maintenance and expansion of educational activities in the health field consisting of:
   a. A program for the basic support of operating costs to maintain these institutions,

b. A program which would give institutions an incentive to expand the training of personnel.

This part of the program would involve Federal expenditures of approximately $10 to $20 million in the first year.

2. Federal aid for the construction of new educational facilities and renovation and expansion of existing facilities for the purpose of increasing the numbers of persons being trained in these fields. This would consist of:

   a. Planning grants to institutions to achieve these objectives ($400,000).

   b. Alteration of existing facilities for expansion ($25,000,000 for first year).

   c. New construction of facilities including expansion of existing schools and establishment of new ones. Within this category, with regard to physician training, priority should be given to expansion of existing schools and the establishment of new two year schools. (The Federal committment would be about $25,000,000 for the first year but actual expenditures would be substantially less.)

3. Federal grants to institutions for scholarships and fellowships for students. This would involve Federal expenditures of about $10 to $20 million for the first year. These educational grants should be available to students so they could attend a medical school without regard to residence or other arbitrary restrictions not related to the ability of the applicant.

The program recommended by the Task Force would involve Federal funds of about $70 to $90 million in the first year. The cost will increase to

about $270 million by the fourth year and is likely to remain at approximately that level. This is only about one half of the existing research grant program of the National Institutes of Health. The expenditure of these sums is essential for national growth and effective performance.

3. MEDICAL RESEARCH

The needs for medical research and research education have been admirably documented in the report to the Senate Committee on Appropriations of the Committee of Consultants on Medical Research under the chairmanship of Boisfeuillet Jones. The principles and recommendations in the Jones report would well serve as a longer-run guide to policy and appropriations in this field.

Federal support of the direct costs of medical research should be continued at approximately its present level for the next fiscal year. However, the educational and research activities of institutions receiving grants from the National Institutes of Health are handicapped at the present time by the limitation in the appropriation act on indirect costs. This limitation now at 15 per cent of the direct cost does not cover the actual indirect expenses. This acts as a deterrent to new research and reduces the available institutional funds for educational purposes. The Federal government as it does in other grants for research, should realistically meet the total costs of the research for which it makes grants through the National Institutes of Health. The first year cost would be about $20 million additional if this policy were applied to initial and renewed research grants only. The longer-run cost of this policy would be about $50 million annually.

4. MEDICAL CARE FACILITIES

The proposed medical care for the aged program will require additional

facilities to be constructed over a period of time. The Hill-Burton hospital construction program has resulted in a significant increase in hospital beds, especially in small communities. There still remains, however, a substantial need for the construction and renovation of kinds of facilities required for the care of the older age group.

The first emphasis should be given to the following components in a program for facilities expansion:

a. An increase in existing Federal grants under the Hill-Burton Act for facilities for long-term care including public and non-profit skilled nursing home and other chronic disease facilities ($10 million annual increase).

b. Long-term low-interest Federal loans for construction, renovation, non-profit hospitals and nursing homes according to approved State plans. ($100 million annually). A combination of loans and grants should be permitted.

c. Long-term low-interest Federal loans for construction, renovation or expansion of facilities for medical group practice and group practice agencies or organization (direct to the groups or agencies concerned, without the intervention of States). ($5 million annually).

An exploration should be made of possible ways in which existing legislation relating to loans to proprietary skilled nursing homes under the Small Business Administration could be amended to increase the proportion of cost guaranteed up to 95 per cent provided the homes met the standards of construction and continued operation prescribed by the U.S. Public Health Service as a part of a State plan.

The Secretary and the Surgeon General should take the leadership and

initiative within existing legislation to encourage the development of outpatient diagnostic and treatment programs. Expansion of services in this setting will be of great importance to the successful operation of the medical care program for the aged.

5. ESTABLISHMENT OF A NATIONAL ACADEMY OF HEALTH

The President should take the necessary steps to arrange for the establishment of a National Academy of Health comparable to the National Academy of Sciences. The purpose of such a non-governmental, independent Academy would be two-fold:

a. To recognize and honor the significant achievements of leaders in health research, teaching, care and administration, and

b. To insure a continuing body of recognized integrity, responsibility of purpose, and breadth of competence for advice to the Government and the public on questions affecting health.

6. CREATION OF A NATIONAL INSTITUTE OF CHILD HEALTH

As an important new step in a broader program for the improvement in family and child health and welfare services, the Surgeon General, with the approval of the Secretary, should, by administrative action establish a National Institute of Child Health within the National Institutes of Health. Such action would recognize the Administration's concern not only with the welfare of the aged, but with its children and youth.

The establishment of the National Institute of Child Health would not require additional federal expenditures for research for the fiscal year 1962. An allocation from existing funds should be made for an initial administrative organization. Subsequent allocations of funds would be included within the budget of the National Institutes of Health.

The high incidence of mental disease, the terrifying problems of juvenile delinquency, the burden on family and community resources for the care of the mentally retarded, all attest to the need for a concentrated attack on problems of the development of the child. Research into the physical, intellectual and emotional growth of the child is at present severely handicapped by the absence of a central focus for research that exists in other fields such as heart disease and cancer. Within this Institute will be concentrated research workers in the fields of genetics, obstetrics, psychology and pediatrics as well as basic scientists who will channel their efforts into the study of the normal processes of human maturation from conception through adolescence.

Such a research program will have a profound impact on the medical care and practice in this nation by emphasizing the care of the whole individual rather than the fragmentation of the patient into particular diseases. The research grants from this Institute will stimulate programs necessary to ascertain those genetic and environmental factors that lead to the development of a physically and mentally healthy adult. Such an Institute should help bring to each child of this nation -- normal, gifted, or retarded -- complete fulfillment of his true potential.

B. SERVICES TO FAMILIES, CHILDREN, AND OLDER PERSONS

A nation's strength lies in the well-being of its people: families, children, and older persons. Welfare services support this well-being in times of stress and constitute, therefore, an essential part of any effective social security program. It seems appropriate after twenty-five years that the welfare grant-in-aid provisions of the Social Security Act, especially those involving families and children, be re-examined to determine how they can be made more adequate to meet current social and economic needs. The following specific recommendations in this section are made with this objective in mind.

7. ASSISTANCE TO CHILDREN OF AN UNEMPLOYED PARENT

In order to meet the growing emergency needs of families affected by unemployment a temporary provision (until June 30, 1962) should be added to Title IV of the Social Security Act which would authorize the inclusion of children in need because of the unemployment of a parent among those eligible for Aid to Dependent Children. The provision would be temporary pending the development of the plan proposed in recommendation 8 and 12.

8. PREPARATION OF A FAMILY AND CHILD WELFARE SERVICES PLAN

The Secretary of Health, Education, and Welfare should be requested to develop for submission to the President and the Congress, prior to the expiration of the temporary amendment to aid to dependent children, a Family and Child Welfare Services plan which would bring together in one program the resources of Federal aid to the States under the Social Security Act for assistance and social services to needy families and children and community social services in such areas as juvenile delinquency prevention, services to the aging, and other related programs designed to strengthen

community life. This would not affect Titles I and X of the Social Security Act relating to the aged and the blind, respectively.

9. STRENGTHENING AND STREAMLINING ADMINISTRATIVE ORGANIZATION

The strengthening of services to families, children, and older persons also could be advanced through administrative action looking to a more effective organization within the Department of Health, Education, and Welfare. The following suggestions should be explored:

a. Elevation of the Children's Bureau from its present location within the Social Security Administration to the Secretary's office to serve its original purpose as a staff agency concerned with all the problems of child life and the promotion of new programs to meet them rather than with program operation.

b. Designation of the Special Staff on Aging as an Office of Aging to advise and assist the Secretary in a similar role with respect to the problems of older persons. This office would not carry any administrative functions.

c. Creation of an Institute of Family and Child Welfare Research associated with the Social Security Administration to combine the present research and demonstration functions enacted in 1956 and now vested in the Social Security Administration, including those of the Children's Bureau in the child welfare field.

d. Transfer of the administration of the Maternal and Child Health and Crippled Children grant programs to the Public Health Service.

e. Transfer of the administration of the Child Welfare Services program to the Social Security Commissioner pending the development of the combined Family and Child Welfare Services plan

recommended in the Task Force Report.

This plan would combine the advantages of assuring spokesmen for the needs of children and older persons at the top level of policy decision in the Department with those implicit in a comprehensive approach to research, health, and welfare services at the operational level. (See also related recommendations 6 and 12).

It appears that no new legislation would be required to carry out these administrative suggestions since all program responsibilities are now vested in the Secretary of Health, Education, and Welfare and he is empowered to carry them out as he sees fit.

C. UNEMPLOYMENT INSURANCE AND THE SOCIAL SECURITY PROGRAMS

The Social Security Act includes provisions relating to unemployment insurance, social security (OASDI) and public assistance. All three programs are in need of expansion and revision to meet the challenge of the 1960's. Moreover, it is essential that some changes in each of these three programs be made at the very earliest possible moment in order to meet the problem of rising unemployment in 1961.

10. IMPROVEMENT OF UNEMPLOYMENT INSURANCE

Unemployment has been increasing over the past several months and has now reached serious, and potentially dangerous, proportions. This is threatening the solvency of some state unemployment insurance systems and in turn the protection for unemployed workers and their families, and business, dependent upon continued flow of income. During the first six months of 1961, it is estimated that 1.5 million persons will exhaust their unemployment benefits. The rate of insured unemployment is estimated at 8 per cent for January and February 1961. Many of the states are not able on their own to meet this crisis, especially since they have only recently emerged from the 1958 recession during which a number of States required federal emergency loans.

Federal emergency legislation is urgently required to provide financial assistance on an optional basis to any states which need and wish such help to strengthen their unemployment insurance systems so they may provide adequately for unemployed workers and their families. Consideration also must be given to the need for assisting the States by the enactment of basic Federal legislation relating to the duration and amount of benefits which will avoid repetition of periodic emergency legislation on a crisis basis

and the undue burden which now falls upon those States experiencing heavy and persistent unemployment.

To maintain the fiscal integrity of the insurance system, any emergency assistance to the States should be charged to contributory income to the Federal Unemployment Account. The emergency grants to the States should not be a charge upon Federal general revenues. The present Federal Unemployment Tax of 0.4 per cent of payrolls should be increased effective January 1, 1962 sufficiently to cover existing and new liabilities arising out of the emergency. Moreover, the taxable wage base should be increased from $3000 to $4800 a year. This in itself will make a substantial improvement in the income to the State programs and to the Federal Unemployment Account. Employers of one or more employees should be brought under the program in order to afford protection to 1.7 million workers now excluded from the system.

An emergency program should make it possible for the States to extend the duration of unemployment payments or to supplement inadequate weekly benefit amounts, or both. There is an urgent emergency need for the Federal government to enable benefits to be extended to at least 39 weeks for persons with a substantial attachment to the labor market. Moreover, States should be given a financial incentive to pay benefits of 50 per cent of wages to most unemployed individuals. An emergency program such as this if adopted by all States would result in an increase in benefits of approximately $150 million a month. Such a program, adopted in February by the Congress, and effective not later than April 1, could put an additional $1,350,000,000 into the buying stream of families during the remainder of 1961.

Detailed proposals relating to both the benefit and financing aspects for the emergency and long-run, consistent with the above principles, have been discussed with the Director of the Bureau of Employment Security in the

Department of Labor and are being prepared by him for the consideration and appropriate action of the Secretary of Labor designate.

11. IMPROVEMENTS IN THE OLD-AGE, SURVIVORS AND DISABILITY INSURANCE PROGRAM

The benefits under the social security program (OASDI) are inadequate. They should be improved and extended as soon as feasible.

In analyzing various proposed amendments the following are the kinds of desirable long-run changes (with the cost of each) which could be considered for inclusion in an immediate program designed to ease the adverse effects of the recession upon individuals and families with the lowest incomes. Adoption of any of these proposals at this time would have both a beneficial short-run and long-run effect. The proposed increased payments would have a two-fold effect: substantially increase benefit protection for social security beneficiaries and reduce the State and Federal expenditures for public assistance from general revenues. Appropriate changes in the financing provisions of the program to meet the costs of any of these changes should be made effective in 1962 or 1963 so that the financial integrity and soundness of the contributory insurance system would be maintained.

The costs included for each proposal are the level-premium (long-run) estimates of the Chief Actuary of the Social Security Administration expressed as a percentage of taxable payrolls.

Proposed Changes in the Social Security Program

1. Provide for paying actuarially reduced benefits to men at age 62 (they are now provided only for women) instead of age 65 (+.05%).
2. A. Provide that an unemployed person aged 60 or over would be considered disabled if he is unable because of a long-lasting impairment to engage in his most recent regular occupation or in other occupations requiring comparable physical and mental capacities, (+.08%).

B. Provide benefits for an unemployed person who is totally disabled for as much as 6 months, even though not permanently, and provide for payment of the costs of rehabilitating disabled workers from the insurance system (+.06%).

3. Make additional people immediately eligible for benefits (about 200,000 by January 1962 and 400,000 by January 1966) by reduding the insured-status requirement from one quarter of coverage for each 3 elapsing after 1950 to one for each 4 quarters, thus bringing the short-run requirements into line with those that will apply in the long-run, when under present law people will be required to have 10 years of coverage out of a working lifetime of about 40 years (+.02%).

4. Increase the minimum monthly benefit from $33 to $50 enabling about 3-1/4 million people to get increased benefits (+.23%). (Alternatively, an increase from $33 to $40 would increase benefits for 1.8 million persons (+.06%).

5. A. Increase widow's benefits from 75 per cent of the worker's retirement benefit to 85 per cent, thus raising the average benefit amount payable to aged widows from $57 to $65 (+.23%).

B. Increase benefits by 10 per cent, with a minimum increase of $5, raising average benefits for retired workers from $74 a month to $81, for young widows from $59 to $65, for orphaned children from $48 to $53, and for the permanently and totally disabled from $89 to $98, (+.93%).

12. IMPROVEMENTS IN PUBLIC WELFARE

The existing Federal-State program of public assistance is inadequate in many respects. The most glaring deficiency is the lack of Federal funds for general assistance for needy persons who are not aged, blind, disabled or

dependent children. As a result of increasing unemployment, the number of individuals on general assistance will increase in many States in the coming months. But in 15 States and two other jurisdictions general assistance is denied if there is any employable person in the family. In 7 additional States employable persons are eligible only in an emergency or for a limited time. In many States local funds limit the availability of general assistance. Moreover, because general assistance is not available in many localities, fathers desert their families so that their needy children may become eligible for aid to dependent children.

The basic solution to this difficulty is for the Social Security Act to be amended to provide assistance to any person in need. This proposal is implicit in recommendation 8. Pending such a basic change, it would be desirable to amend the aid to dependent children program as outlined in recommendation 7.

A temporary amendment to provide for the children of unemployed fathers under Title IV of the Social Security Act would involve a Federal expenditure of between $150 million to $275 million for the fiscal year 1962. The larger figure is based upon the assumption that all States take advantage of the option to amend their programs. The lower figure is based on the assumption that only the major industrial States seriously affected by the recession will take advantage of it.

There are a number of other amendments in public welfare legislation which are long overdue. These changes are outlined in the reports of the Advisory Council on Public Assistance and the Advisory Council on Child Welfare Services. The recommendations in these reports which were requested by the Congress should be implemented as soon as practicable.