

PUBLIC HEALTH PROVISIONS OF THE SOCIAL SECURITY ACT

EDGAR SYDENSTRICKER*

The Social Security Act of August 14, 1935 is unique in that it is the only piece of national legislation enacting social insurance here or abroad which, at the same time, provides for direct means of prevention of ill health as one of the principal causes of economic insecurity. In all other countries, so far as the writer is aware, efforts to mitigate or eradicate any specific cause of insecurity is undertaken by legislation which is either entirely separate from efforts to lessen the effects of such causes or provides only indirectly for preventive measures. Title VI of the Social Security Act definitely authorizes appropriations by the Congress for "public health work."

This provision was not at first contemplated when, in the summer of 1934, the Committee on Economic Security was appointed by President Roosevelt. Even when the Committee assembled a technical staff to study the problems of economic insecurity, health insurance was specified as the only topic for inquiry in the field of health. This was done probably because health insurance is almost universally included in other modern countries as a form of social insurance. It was not long, however, before the technical staff to which the subject of health was specifically assigned realized that health insurance was only one method by which certain risks to economic security might be lessened. In fact, a simple analysis of the problem showed that the principal risks to economic security arising out of ill health could be classified into three broad categories, as follows:

- (1) Loss of efficiency and health itself and thus loss or impairment of the capacity to be employed;
- (2) Loss of earnings resulting from disabling illness among gainfully employed persons;
- (3) Costs of medical care to gainfully employed persons and their families.

*M.A., 1902, Washington and Lee University; post-graduate study, Washington and Lee University, University of Chicago, and Johns Hopkins University. Scientific Director, Milbank Memorial Fund, 1928-1936. Member of the technical staff of the Committee on Economic Security, 1934-1935, in charge of studies of risks to economic security arising out of ill health. First public health statistician, United States Public Health Service, 1915-1928, and consultant, thereto, 1928-1936. Chief of Service, 1923-1924, of the epidemiological intelligence and public health service, League of Nations, in initiating the statistical work of the League's international health organization. Author: *Collective Bargaining in the Anthracite Industry*; *Conditions of Labor in the United States*; *Brief History of Taxation in Virginia*; *Health and Environment*; also author of various scientific articles and bulletins on epidemiology, social research, etc.

Any opinions presented in this article are, of course, the author's views as an individual.

NOTE: It is with profound regret that we report the death of Mr. Sydenstricker on March 19, 1936. Ed.

It was also clearly recognized that no one method of attacking all of these risks had as yet been devised. Some students of the problem have argued that the problem of economic security, including security against risks arising out of ill health, could be solved by indirect means, such as unemployment compensation, old-age annuities, wage increases, stabilization of employment, housing programs, limitation of size of family, and the like. But comprehensive studies which have been made during the past decade have clearly shown that such indirect, Utopian methods have not solved the problem. Even if every family or every individual should have an income equal to what Dr. Townsend proposes for persons over 60 years of age, many could not bear the expenses of serious illness if the physician is to be adequately paid and the hospital kept out of debt. As a matter of fact, there are ample statistics amassed in this country to show that disabling sickness is an unpredictable expense to a large proportion of the people. As the report of the Committee on Economic Security to the President pointed out, among an average million persons in the United States, there will occur annually between 800,000 and 900,000 cases of illness. It may be predicted for this average million persons that, though 470,000 will not be sick during a normal year, 460,000 will be sick once or twice, and 70,000 will suffer three or more illnesses. Of those who become ill, one-fourth will be disabled for periods varying from one week to the entire year. These illnesses are exclusive of invalidism.

The Committee's staff made comprehensive studies of all of the probable risks to economic security arising out of ill health, as outlined above. The report of the Committee to the President of January 15, 1935, however, included only the recommendations on the first of these risks. It was stated in that report that more time was required to consider possible methods of adapting the principle of insurance in this country to the risk of loss of wages from illness and to the risk of expense of medical care. Those members of the Committee's technical staff who were charged with the study of health insurance properly, I think, recognized the fact that individuals and agencies rendering medical services—the physicians, nurses, dentists, hospitals, and clinics—were involved, both financially and professionally. The staff therefore recommended to the Committee that before any system of health insurance should be proposed, the medical and nursing professions and institutions should be consulted and that ample time should be allowed to discover how the insurance method of distributing loss of wages due to ill health and costs of medical care could best be employed in this country. This attitude, adopted at the very outset of the Committee's work, is in striking contrast to the action of the principal foreign countries in initiating health or sickness insurance. Various advisory committees in medicine, dentistry, hospital management and nursing were appointed and lengthy conferences were held. The technical staff of the Bureau of Medical Economics of the American Medical Association were consulted. All of these steps are described

in the report of the Committee on Economic Security to which reference has been made.¹

The question of health insurance, however, was still further deferred for later consideration probably because it was generally felt that every opportunity should be given to the medical profession to study the matter and to propose other ways of meeting the problem of economic insecurity due to ill health, if it saw fit. The omission of any provision in the Social Security Act for insurance against unemployment due to temporary (non-industrial) disability cannot, however, be wholly justified on these grounds, and the insurance features of the Act would, in the writer's opinion, have been more effective and acceptable if cash benefits for sickness had been provided. The actuarial problems involved in such a provision are simple compared to those of compensation for unemployment from other causes, and the provisions could have been put into effect within a year after the Act was passed.

The Committee's report, however, pointed out, with an emphasis probably never before given in a document of its character, that efforts to *prevent* sickness itself constitute a legitimate method of coping with the risk of sickness. The incidence of preventable sickness itself, it was urged, was a problem of social concern. Although science has not provided all of the means with which to prevent all sickness, or to enable everyone to live healthfully until the end of the natural span of life, millions of the American people are suffering from diseases and over a hundred thousand of them die annually from causes that are preventable if existing scientific knowledge could be applied. It is hardly necessary to refer in detail to the indubitable evidence on this point. All of the general public may not be fully aware of the possibilities of disease prevention, but sanitarians—the professionally trained workers in public health—are optimistic over these possibilities and need only relatively small appropriations with which to realize them. As I have said elsewhere,² “the ravages of typhoid fever, diphtheria, and smallpox have been enormously lessened; they ought to be and can be eradicated. The infant death rate has been cut in half in the last quarter-century, but it can again be cut in half. Mortality from tuberculosis has been reduced by 60 per cent since 1900, and could be halved again. Two-thirds of the annual thirteen thousand maternal deaths are unnecessary. At least three-fourths of a million cases of syphilis are clinically recognized annually; but more than half of these do not obtain treatment at that stage of the disease when the possibility of cure is greatest. We have been rather vociferous in recent years over the health and welfare of children; yet it is estimated that 300,000 are crippled, a million or more are tuberculous, and nearly half a million have heart damages or defects. The mortality of adults of middle or older ages has not appreciably diminished. The expectation of length of life at forty is about the same now as it was in 1850, 1890, or 1900. The mortality of adults who should be in their physical prime—20-44 years

¹ COMMITTEE ON ECONOMIC SECURITY, REPORT TO THE PRESIDENT (1935) 6, 38-43. For the personnel of the advisory committees on public health problems, see *id.* 52-53.

² Sydenstricker, *Health Under the Social Security Act* (1936) 10 SOCIAL SERVICE REV. 14.

of age—is almost as great as that of the younger group which includes babies and children. The mortality of persons who ought to be in full mental vigor and still capable of many kinds of physical work is over three times that of the younger adults. In the young adult ages, 20-34 years, tuberculosis still tops the list as a disease; accidents and homicides snuff out about one life in a thousand annually; organic heart disease appears in even this young age period as the third most important cause of death. All careful studies of illness and physical impairments corroborate these ghastly records; in fact, they reveal even more impressively than mortality statistics the extent to which the vitality of the population is damaged in the most efficient period of life. This disconcerting evidence of impaired efficiency among our adult population takes on a graver significance in view of the changing age of our adult population.”

It is to the lasting credit of the Committee on Economic Security that in its report to the President it fully recognized the significance of the public health situation. In this report the Committee said:

“It has long been recognized that the Federal, State, and local Governments all have responsibilities for the protection of all of the population against disease. The Federal Government has recognized its responsibility in this respect in the public-health activities of several of its departments. There also are well-established precedents for Federal aid for State health administration and for local public facilities, and for the loan of technical personnel to States and localities. What we recommend involves no departure from previous practices, but an extension of policies that have long been followed and are of proven worth. What is contemplated is a Nation-wide public health program, financially and technically aided by the Federal Government, but supported and administered by the State and local health departments.”³

The specific provisions in the Social Security Act of August 14, 1935, relating to public health are as follows:⁴

TITLE VI—PUBLIC HEALTH WORK

APPROPRIATION

SECTION 601. For the purpose of assisting States, counties, health districts, and other political subdivisions of the States in establishing and maintaining adequate public-health services, including the training of personnel for State and local health work, there is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of \$8,000,000 to be used as hereinafter provided.

STATE AND LOCAL PUBLIC HEALTH SERVICES

SEC. 602. (a) The Surgeon General of the Public Health Service, with the approval of the Secretary of the Treasury, shall, at the beginning of each fiscal year, allot to the States the total of (1) the amount appropriated for such year pursuant to section 601; and (2) the amounts of the allotments under this section for the preceding fiscal year remaining unpaid to the States at the end of such fiscal year. The amounts of such allotments

³ At p. 40.

⁴ A few provisions relating to matters of administrative routine have been omitted.

shall be determined on the basis of (1) the population; (2) the special health problems; and (3) the financial needs; of the respective States. . . .

(b) The amount of an allotment to any State under subsection (a) for any fiscal year, remaining unpaid at the end of such fiscal year, shall be available for allotment to States under subsection (a) for the succeeding fiscal year, in addition to the amount appropriated for such year.

(c) Prior to the beginning of each quarter of the fiscal year, the Surgeon General of the Public Health Service shall, with the approval of the Secretary of the Treasury, determine in accordance with rules and regulations previously prescribed by such Surgeon General after consultation with a conference of the State and Territorial health authorities, the amount to be paid to each State for such quarter from the allotment to such State, and shall certify the amount so determined to the Secretary of the Treasury. . . .

(d) The moneys so paid to any State shall be expended solely in carrying out the purposes specified in section 601, and in accordance with plans presented by the health authority of such State and approved by the Surgeon General of the Public Health Service.

INVESTIGATIONS

Sec. 603. (a) There is hereby authorized to be appropriated for each fiscal year, beginning with the fiscal year ending June 30, 1936, the sum of \$2,000,000 for expenditure by the Public Health Service for investigation of disease and problems of sanitation (including the printing and binding of the findings of such investigations), and for the pay and allowances and traveling expenses of personnel of the Public Health Service, including commissioned officers, engaged in such investigations or detailed to cooperate with the health authorities of any State in carrying out the purposes specified in section 601: *Provided*, That no personnel of the Public Health Service shall be detailed to cooperate with the health authorities of any State except at the request of the proper authorities of such State.

(b) The personnel of the Public Health Service paid from any appropriation not made pursuant to subsection (a) may be detailed to assist in carrying out the purposes of this title. . . .

(c) The Secretary of the Treasury shall include in his annual report to Congress a full account of the administration of this title.

In the deficiency appropriations made by the 74th Congress during its present session, the first appropriations were made in accordance with the provisions given above. Prior to that, however, the United States Public Health Service, to which the task was given of allotting funds to states and of the expenditure of additional money, had prepared a series of regulations. With the cooperation of state and territorial health authorities, Surgeon General Hugh S. Cumming and his staff considered the most useful and practicable ways in which the funds authorized by the Social Security Act might be utilized. It was fully realized by them that sufficient information was not available to determine accurately the special health problems and needs in every community in the United States. Hence the regulations agreed upon by the state and territorial health authorities and issued by the Public Health Service are regarded as more or less temporary. In the meantime, the President allotted to the Public Health Service the sum of about three and a half million dollars from work relief funds for the purpose of making a national health survey and inventory

of health facilities of all kinds throughout the nation. This survey and inventory are now in progress.

It may be of interest to summarize briefly the regulations⁵ governing allotments and payments to states from funds appropriated under the Social Security Act for the fiscal year 1936 as an indication of how the federal health authorities propose to expend these funds.

The Social Security Act provided, it will be recalled, for allotments to states of federal grants-in-aid (at the rate of eight million dollars per annum) on the basis of (1) population, (2) special health problems, and (3) financial needs. With respect to population as a basis, allotments are now being made to the several states on a per capita basis amounting to 57½ per cent of the total sum available. The allotments for special health problems, including the training of public health personnel in the states, will amount to 22½ per cent, and allotments on the basis of financial need will be made with the remaining 20 per cent. The regulations also provide that in order to be eligible to receive such allotments, each state "shall present a comprehensive statement of the present organization program and budget for state health work within the state, together with a proposed plan for strengthening or improving the administrative functions of the state department of health and for administration of local health service." It is understood that the Public Health Service will propose standards of organization and qualifications of personnel as recommended by the Conference of State and Territorial Health Officers. Furthermore, before any payments can be made, it was provided that each state health officer shall submit to the Public Health Service the proposed budget for each project, showing the distribution of funds from all sources and the items required from the Public Health Service.

An important provision in the regulations issued by the Public Health Service is that payments from the funds available under the Social Security Act are not to replace existing state and local appropriations. In other words, it is definitely intended that the federal money shall be "new money." Furthermore, the regulations are designed not only to encourage the maintenance of local and state appropriations but also to stimulate increased state and local appropriations for public health. For example, one-half of the payments to states on the basis of population shall be available for payment when evenly matched (dollar for dollar) by existing appropriations; the other half shall be available for payment when evenly matched by new appropriations of public funds for health purposes. The additional provision is made that the part of the funds made available for matching by existing appropriations shall decrease at the rate of 10 per cent per annum on the average, so that after 10 years, the entire fund paid to states on the basis of population shall be matched by an increase in appropriations until such time as an average expenditure of \$1.00 per capita should have been reached by local health services within the state.

⁵ These regulations have been published in (1936) 26 AM. J. OF PUBLIC HEALTH, 59-62.

When this limit is reached, it will be permissible to match the entire fund with existing appropriations for state and local health services.

The same general provisions govern payments on the basis of special health needs. Special health needs are interpreted to mean "necessity arising out of high morbidity or mortality on a state-wide basis from particular causes, such as malaria, hookworm, bubonic plague, trachoma, typhus fever, special industrial hazards, and similar geographically limited diseases or other conditions that result in inequality of exposure to public health hazards among the states." Under special health needs is also the training of personnel. It is well known that a sufficient number of technically trained persons is not available for rapid expansion of public health work. In fact, those who were responsible for initiating the recommendations which formed the basis of Title VI of the Social Security Act realized that several times the amount authorized could profitably be spent for the prevention of disease if adequate personnel and facilities existed. In the interest of true economy, however, only eight million dollars was proposed, a sum which is relatively insignificant in comparison with federal expenditures for relief, national defense, and other essential purposes. The Public Health Service, recognizing that additional personnel was a special health need, provided in its regulations that 12½ per cent of the total sum shall be set aside for establishing or strengthening suitable training centers and for stipends and expenses of persons who are untrained. This money need not be matched by the state.

Finally, payments on the basis of financial need are being made by two methods. One is a flat allotment of five per cent of the total amount available to the 51 state and territorial health jurisdictions to which the Act applies.⁶ For the purpose of assisting the state or territorial health departments and "providing the leadership and administrative guidance necessary for the effective use of federal aid," a payment of five per cent is provided which will not be required to be matched. The second method is by an "equalization fund" of 15 per cent of the total amount available which "shall be expended exclusively for local health services" and which "shall be distributed among the states most urgently in need of financial assistance, the need being determined on the basis of the financial ability of the state as expressed indirectly in terms of per capita income." No requirement for matching these funds is made.

The payments to the states are to be made in such installments and at such times as the Secretary of the Treasury may direct, to the treasurer of the state or other state official authorized by law to receive such funds. Financial reports are to be made to the Surgeon General of the United States Public Health Service as he may require and unobligated balances as of the close of business on June 30th of each year shall be returned to the Treasurer of the United States.

It is difficult at this time to form an opinion as to the consequences of these pro-

⁶The 48 states and the territories of Alaska, Hawaii, and the District of Columbia.

visions of the Social Security Act and of the regulations which have been worked out by the Public Health Service with the state and territorial health authorities. There can be no doubt that a tremendous stimulus will be given to disease prevention throughout the country. In only about 600 of the 2,500 rural counties in the United States does there exist even a skeleton public health organization. Of these less than one-quarter have facilities which are regarded as adequate. As fast as trained personnel can be secured, the Social Security Act will make more health services available to these neglected communities. In hundreds of small towns and cities the health services are inefficient and inadequate; the Social Security Act will supply a stimulus to their improvement. The federal health service itself will be strengthened by additional direct appropriations in its fight against such health problems as malaria and hookworm in the South, in the study of special industrial hazards, and in conducting the basic research necessary for the discovery of practical methods of disease prevention. On the other hand, there will be some who will fear that the Act confers upon the federal government a degree of control of states and localities with respect to public health functions which was not contemplated by the framers of the Constitution. Of course, the framers of the Constitution lived in a day when public health functions of government were never heard of. But the Act itself is based on precedents long established. Frequently in the past the Congress has made appropriations for grants-in-aid to states for public health services. It has more than once given the Public Health Service authority to attack health problems regardless of state boundaries. Furthermore, the regulations governing the use of grants-in-aid to states are not imposed by the federal Public Health Service; they have been worked out in collaboration with the state and territorial health authorities and have been accepted by them. Transcending all possible objections is the fundamental principle which has been reiterated by various Presidents and statesmen, namely that the conservation of vitality and the promotion of health are the first concerns of the State. If the "welfare clause" of the Constitution means anything at all to the average citizen, it definitely may be interpreted to include such direct measures for the preservation of life and happiness of the people as science has proved to be effective.