THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM, 1943 -- 1946

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CHAPTER I

INTRODUCTION

From Controversy to Agreement:

To those who study or are associated with a social movement the standard device that is a part of almost every detective story has great value. At appropriate intervals the evidence or the progress is summarized and the question "Where do we stand now?" is answered. The purpose is to clarify the evidence and indicate next steps.

In any social movement it is one of the human weaknesses to continue a form of shadow-boxing with issues that no longer exist. Though the action may be fast and the motions graceful little is accomplished and an enormous amount of energy is misdirected. It is to conserve and use the energy where it will produce the greatest values that the question "Where do we stand now?" needs to be posed and answered at regular intervals.

Few will question that the distribution of the health services—medical care, dental care, nursing, hospitalization and others—comprises a broad social movement in the United States and over the world. The movement has assumed such large proportions that, accompanying it, there has developed a new field of study. By some it is called "social medicine;" by others, "medical economics" or "public health economics" and, as with other movements, this one has evolved in the United States to a point where its issues must be re-defined.

Only a few years ago the principle of health insurance or pre-payment for services, was debated vigorously. No matter how it might be applied the principle was described as a dangerous innovation.
in American medical economics, an "entering wedge." That issue was settled in 1934 when the principle received professional endorsement and, as evidence of public approval, resulted in the rapid growth of prepayment plans under hospital or medical society auspices. Thus, health insurance, per se, is no longer an issue and those who expand energy either in defending or opposing it are shadow-boxing.

With minor exceptions, the health insurance plans in the United States provide limited services. Dentistry is excluded, only the general nursing of hospital cases is provided, there are limits upon hospital services and, as a rule, only surgical and obstetrical care for hospital cases may be obtained from the majority of existing plans. The significant fact, however, is the general trend toward expansion and the general agreement that comprehensive services are desirable. To be sure, there is some preoccupation with the question of insuring against "catastrophes." But no student of the subject, with the facts available concerning the income-groups in the country, who takes seriously the professional advice "See your doctor early" or who has an awareness of the importance of preventive services, would try to define a catastrophe in terms of such limited needs of services as surgery and hospitalization. The desirability of a comprehensive plan has been expressed by the laity and the objective of a comprehensive prepaid service has been approved by the medical profession. Thus, the issue of prepayment for comprehensive services has become one for historical consideration.

What about the issue of a national health plan? When prepayment received official professional endorsement it was emphasized that its application should be localized. Experience in Michigan
and California pointed to the desirability of state programs and professional approval followed the demonstrations. Some time later, in 1946, after it became evident that state boundaries were artificial barriers to the future success of the health insurance schemes professional support was given to a national health plan. To further this development a central office was established in Chicago under the auspices of the Associated Medical Care Plans, Inc. to integrate the activities of state and local plans and to evolve a national medical program. Prior to this step an office called the Blue Cross Commission had been established by the American Hospital Commission to integrate the work of the Blue Cross hospital insurance plans.

Where do we stand now? Health insurance or prepayment is not an issue; neither is prepayment for comprehensive services. Nor can the desirability of a national, comprehensive prepayment plan be described as a subject of major disagreement. All these are now issues of the past.

The chief issue in the United States is the organization and administration of a national, comprehensive prepayment plan. Within the framework of this issue there are the many problems or sub-issues that are exciting much discussion. Yet, even here, within the major issue, rapid changes are taking place.

As an example of change within the primary issue of organization and administration, one of the much-discussed and debated subjects is that of compulsory versus voluntary health insurance. The earlier sharpness that typified the differences of opinion is found more in the words used now than in the actions either taken or proposed. As an index of the trend, when hospital plans were first organized employer contributions were not stressed. In some
instances employer contributions were opposed as a violation of the principle of voluntary acceptance or rejection of hospital prepayment by employees. In recent years more and more emphasis has been given to employer contributions and many of the plans regard such contributions as vital to a successful sales policy. At the same time there is the growing tendency to include the protection of health insurance in employer-employee contracts as a result of collective bargaining.

Recently a responsible medical leader, in his presidential address, expressed strong opposition to compulsory health insurance. At the same time he recommended a scheme whereby the employer would be compelled to purchase protection for his employees from voluntary health insurance plans. Thus, in the actions taken and the proposals made, the basis of the sub-issue, compulsion versus volition, shows signs of disintegration. Just as opposition to the principle of health insurance changed to approval, if the principle were applied in certain ways, so there appears to be a tendency to recede from the opposition to compulsion provided that it is applied in certain ways. The chief point here is that significant change is taking place.

What has been said about compulsion is also applicable to the debate concerning the role of government. Here, too, the sub-issue shows signs of disintegration. Apparently as a recognition of the fact that voluntary insurance is wholly or partially beyond the means of low-income and low-income families the recommendation has come from existing plans that government subsidize the purchase of health insurance for these groups. As another example, the sharp

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comments in opposition to any government role, and particularly a federal role, in the organization and administration of medical services are at odds with the actions of the medical profession in urging state and local medical agreements with a federal agency, the Veterans Administration, for services to veterans.

These and other signs point to rapid change, to the need of a continuing analysis of existing problems and to the importance of directing efforts toward the solution of problems that appear in the foreground rather than the background of events. In too many of the writings and the discussions there has been an unwarranted emphasis upon the elements of past controversy. Yet, the most striking feature of this whole social movement is not the controversy but rather the agreement that has evolved in a little over a decade.

Social Experiment:

The question of how a social idea, such as a national health plan, may work when transformed into a social institution can never be settled by conflicting theoretical charts. Such charts have certain of the touches and devices used by the ancient cartographers. There are areas of unknowns; by some they may be drawn in dark and forbidding colors, inhabited by monsters; by others they may be pictured in attractive pastel shades. It is little wonder that confusion results.

Too much of the discussion of a national health plan has about it an air of unreality. The comparable picture is somewhat like that of the old philosophers, who, probably sitting on the sunny side of the Tower of Pisa, debated the subject of whether a heavier body would fall a given distance faster than a lighter one. "Pure
logic" provided the answer that it would, so it was absurd to subject the conclusion to any test - and climbing towers is very tiring. The tower was there, light and heavy objects were available but why bother - until Galileo demonstrated by the experimental method.

The experimental method is both the product and the pride of modern science and attracts strong professional and popular support. Is it possible to use it in connection with a national health plan; to subject proposals and methods to critical test as a means of reducing the area of unknowns? At first thought the application of the experimental method to a national health plan appears to be fanciful. Trial and especially error on such a grand scale would result in confusing conflicts. When, however, the issues and problems of a national health plan are organized and classified and when they are examined in the light of what has been happening in the United States the possibilities of the experimental method become real and within reach.

Over the country there are, literally, dozens of "experimental laboratories" in which there are rich collections of information. While a national health plan is being discussed in theory, on all sides there are to be found the elements of a national health plan, in fact. Blue Cross hospital plans, medical society plans, relief plans, rural plans - these and many others contain partial answers to questions that are being discussed as if no experience exists.

More significant, while theoretical discussions of a national health plan have been taking place, at least six actual national health plans have been started and five of these are operating now. All this has occurred within the decade when the debate has been most vigorous. It makes little difference that three of the national
health plans were launched as emergency measures; all presented many answers to many questions that are being discussed currently - questions of centralized or decentralized governmental authority, of professional relations, of actuarial experience, of facilities, the quality of services, the form of payment and others.

With six national health plans in a little over a decade what was learned? The first one was the huge relief program that was financed by the federal government for over twenty million people in every part of the country. Under Rules and Regulations No. 7 issued by the Federal Emergency Relief Administration "Governing Medical Care Provided in the Home to Recipients of Unemployment Relief" what were the details of organization and administration in the states and local communities? Where did the system work well, where did it prove defective - and why? What were the expressed needs of the people, what services were given, how well did the various forms of payment work? As with other missed opportunities there are no answers to these, the same questions being asked now and for which answers supported by experience could have been obtained. Thus, a national health plan that involved professional personnel and patients was in operation for about eighteen months and it ended with virtually nothing added to the knowledge of public health economics.

The next two national health plans were started in 1936. One was the program of the Farm Security Administration for low-income farmers. The rural health problem has been a perennial subject of discussion with emphasis upon the lack of facilities and personnel, the needs of the people and the difficulties of arranging for the payment for services. But here was a program that, eventually, was to provide, within the limits of available facilities and personnel,
services in over a third of the counties of the country to a total of more than 70,000 families in 1944. Here, too, was a program that should have excited the critical attention of every agency that claims to have an interest in public health economics. The opportunity to analyze the possibilities: the strengths and the defects of local control, rather than state or national; and of local organization and administration, including the utilization of facilities and personnel; costs and other pertinent subjects was made to order. But, except for those studies made within the administrative agency itself, the Farm Security Administration program grew to a peak and declined without exciting more than ripples of sporadic interest in few of its controversial elements. The laboratory for the study of rural health organization and administration by independent agencies was not utilized.

The other program established in 1936 was the one for crippled children authorized by the Social Security Act and administered by the Children's Bureau. This program is continuing and the policies and procedures developed for carrying it on deserve close study from many standpoints. Some of these are federal-state administrative relationships, state-local administrative relationships, development of cooperation between public and private agencies, determination and maintenance of standards, and many others. The evidence is there and only awaits analysis.

The fourth national health plan is the one that forms the foundation of this report. At its peak the Emergency Maternity and Infant Care program exerted its influence upon virtually every community in the country. Despite the sharpened interest in a national health plan little attention was given to EMIC, probably because of
its "emergency" aspects. But, emergency or not, valuable current experience was accumulating. The program included a wide variety of administrative techniques; it faced the development of national, state and local policies; it involved much of the subject of payment, including the basis, the method and the amount; it established procedures for professional and public relations and it offered valuable material on the problems of standards and the quality of services. This is not to say that in all of these aspects of organization and administration the EMIC contributions were positive and satisfactory. Errors were made; certain ambitions exceeded accomplishments but the experience, whether positive or negative, offers much of value to those interested in a national health plan.

While this report is being prepared a fifth national health plan, that of the Veterans Administration, is being formulated. The Veterans Administration has provided health services for many years but the reason for classifying its program as a national health plan is the introduction of a new element in 1946. The element is "home town care" for veterans with service-connected disabilities. The care is provided by private practitioners, hospitals, etc. in local areas in accordance with agreements arranged by the Administration. All evidence points to the rapid spread of the program until, like EMIC, it covers the country. Many of the problems to be solved are comparable to those of EMIC or any national health plan. Once again a laboratory is being created.

Finally, a sixth national plan, that of Vocational Rehabilitation, is expanding and using, more and more, the health facilities of the nation. Here, too, is a laboratory with problems comparable to those of EMIC and the Veterans Administration. It is not an
unreasonable conclusion that what these laboratories produce should be given tangible weight in evaluating any future proposals that may be made.

The EMIC Study:

It was during 1944 that the possibilities of the EMIC program as a research laboratory in public health economics became self-evident. Two obstacles, neither minor, stood in the way of an acceptable critical study. The first was the financing of such a study; the second was the possible attitude of a government agency toward an analysis of its administration.

As a rule federal agencies exhibit a restrained enthusiasm toward any proposed analysis of their activities. This is especially true when the study involves a controversial subject and when the research is in the control of a non-governmental organization. It is, therefore, to the high credit of the Children's Bureau that when the proposal for study was presented the response was one of complete approval. And during the course of the study the approval was supported by the actions and the attitude of the staff. The research workers were given complete freedom; the files of correspondence, including recommendations, complaints and criticisms were open to review, and stenographic reports of intra-agency conferences on the operation of the EMIC program were made available.

Financial support of the research project was granted by two foundations, the New York Foundation and the Marshall Field Foundation. To both foundations the project was presented as a study intended to contribute to the chief issue in public health economics, the organization and administration of a national health plan. Following favorable action by the foundations the preliminary preparations for the study began in the late fall of 1944.
The methods of study included an analysis of the enormous amount of material in the office of the Children's Bureau - Congressional hearings and actions, financial data, plans from the states, administrative rules and regulations, correspondence, reports, and statistical data. But the primary emphasis of the study was upon the field work. Maternity and infant care are services provided to people living in local communities within states and how the program worked could be learned only by visiting a cross-section of states and communities. It was here that the answers to vital questions would be found.

The selected states included Massachusetts, New York, Michigan, Illinois, Georgia, Mississippi, Nebraska, and California - north, south, east and west. Within the areas selected there are to be found virtually all of the variables that may be expected to influence the organization and administration of a national health plan - social extremes, economic extremes, professional extremes, with each set of extremes showing the in-between gradations that make up the average.

Much of the work in the field was devoted to interviews. Whether 55 or 110 babies had been delivered in a particular community was a secondary matter but the attitudes, the opinions, the experiences, the suggestions and the recommendations of those who lives had been touched by the EMIC program were important. And an amazing number of people were in this category. Physicians, dentists, nurses, public health workers, social workers, hospital administrators - these, aside from over a million patients in the country, make up the groups to whom EMIC was more than four letters of the alphabet.
In preparation for the study the field staff discussed and revised the patterns of the interviews and agreed upon the type of data that would be sought. It was and is recognized that such an approach, except for the factual supporting data, is a subjective one. Within the study the only method of controlling errors was to check the conclusions of field staff, wherever possible, through discussions of their findings and comparisons with views expressed in the medical journals and with the opinions of administrators.

A much better control would have been possible if two or three other agencies with an expressed interest in public health economics had undertaken a comparable study.

Throughout the report the phrase "national health plan" will appear. This has no reference to any single proposal that has been presented. The major problems that are discussed are problems that attend the process of organization and administration. It is a grave mistake to interpret these problems as less weighty for a voluntary than for a compulsory plan. Whatever the suspicions the plan requires organization and administration.

Attention is directed, also, to the important fact that in the presentation of problems the phrase "state health plan" might well replace "national health plan" if one has in mind such states as California, New York, Ohio, Illinois, Michigan and many others. Within the populous states are found the majority of the administrative problems that face the nation; what differences exist are variations in degree.

In the succeeding chapters of Part I descriptions of the Children's Bureau and the EMIC program are presented. These are intended to provide the atmosphere and the setting within which the organization and administration of a national health plan developed.
CHAPTER II

THE CHILDREN'S BUREAU

The Establishment of the Bureau, 1912:

There are many lessons contained in the series of events that led to the establishment of the Children's Bureau by an act of Congress in 1912. Viewed in retrospect the events preceding and during 1912 form the pattern of action that, then and now, culminates in a new law or a new agency.

One of the standard criticisms that attends any proposal for social legislation is that it was inspired by "small interested groups" or by "professional social workers." The question is usually asked: Where is the evidence of widespread public demand? It is implied that public demand is something that has a spontaneous origin and that unless a proposal originates in an upsurge, a tidal wave, of public opinion its validity is in question.

Social legislation and for that matter other types, as well, develops in successive stages. Individuals or small groups become aware of a particular situation; they write, they speak, they recommend, they begin to focus public attention upon what they conceive to be the need. To them this becomes the "most important" problem that calls for public action and by their activities they arouse the interest of more and more people. Organizations take action in favor of the proposals to solve a problem; public polls are used both to obtain a measure of public opinion and to educate; sponsoring committees are organized and funds are collected to acquaint greater and greater numbers with the need for action.

While this is going on members of Congress become a part of the spirit of interest and translate the proposals into the tangible form
of recommended legislation. Thus, what started as the interest of a small group finally emerges as a legislative act. And the progress from interest and support by a small group to strong public demand does not differ markedly whether the proposal has to do with a new medical practice act or the organization of a new government agency.²

An important event leading to the creation of the Children's Bureau is reported to be the suggestion of Lillian D. Wald, founder of the Henry Street Settlement in New York City, to President Theodore Roosevelt in 1906 that such a governmental agency be established.¹ As stated by Julia C. Lathrop, the first chief of the Children's Bureau, it is no mere coincidence that "this Bureau was first urged by women who have lived long in settlements and who by that experience have learned to know as well as any persons in this country certain aspects of dumb misery which they desired through some governmental agency to make articulate and intelligible."² Some of the dumb misery referred to was, of course, the need as seen in the city slums for an effective program of maternal and child welfare.

Mrs. Florence Kelley, head of the National Consumer's League and Miss Wald were influential in bringing the National Child Labor Committee into the struggle. This committee drafted the first bill for the creation of the bureau which was first presented to Congress in 1906 and 1907 and also maintained a lobbying and pressure office in Washington for four years until the proposal was approved.³

¹The same description would apply to the "build-up" of opposition to a proposal.
The proponents for the institution of a bureau began to increase in great number and influence. They argued for a center of research and information concerning the welfare of mothers and children. Obviously without a sound basis of information no intelligent and effective maternal and child welfare program could be formulated. Information and statistics on maternal and infant mortality and morbidity, juvenile delinquency, nutrition, and child labor and related problems were sorely lacking. It was argued pointedly that the Federal government had already established agencies to serve as centers of research and information in other fields, such as agriculture, and it might well look to the welfare of one of the more important resources of the country - children.

Finally, success was achieved in enlisting the active interest of Congress. Many bills directed toward the creation of the Children's Bureau were introduced from 1909 to 1912, and extensive hearings were held on each one.\(^4\) As an indication of the strong support that had been mustered, an imposing array of organizations and influential individuals appeared before the Congressional committee to testify in favor of the provisions of the bills. Among them were the late Jane Addams of Hull House of Chicago, Judge Ben Lindsay of

juvenile court fame, and the representatives of many powerful organizations such as the National Consumer's League, the State Charities Aid Association, the American Association for Labor Legislation, and the Russell Sage Foundation. All stressed the pressing need for information and statistics stating that while there would be no compulsion on the states to utilize the information they would be encouraged to enact sound child welfare laws on the basis of such information. One interesting argument proposed was that it "would multiply the efficiency of private philanthropy." There seemed to be little evidence of opposition to the bills; the task at hand was apparently one of bringing pressure upon Congress to take concrete and final action. President Theodore Roosevelt and, later President Taft lent their prestige and influence.

Although there was unanimity of purpose as to the functions of the proposed bureau, considerable disagreement arose as to where it should be placed in the governmental administrative machinery. The three alternatives suggested at the time were the Bureau of Labor and the Bureau of the Census, both in the Department of Commerce and Labor, and the third, the Bureau of Education in the Department of the Interior. It was apparent that the work of the proposed bureau would perhaps overlap all these agencies. The Bureau of Labor was concerned primarily with working conditions which would also relate to the working conditions of women and children; the Bureau of the Census collected vital statistics concerning mothers and infants; and the Bureau of Education dealt with the education and school environment of the child. The United States Public Health Service, then a part of the Treasury Department, was not considered, at least not in the records of the hearings. This may have been due to the
broad social service aspects of the proposed bureau overshadowing
the health aspects. In any case, the three bureaus mentioned above
were reluctant to accept responsibility for the work of the proposed
bureau, and their chiefs admitted as much in the hearings on the
bills. They did, however, offer to cooperate with the new bureau
wherever it might be placed.

The sixty-second Congress passed the measure sponsored by
Senator Borah, and it was approved by President Taft on April 9, 1912.
The Children's Bureau, as it was originally named, was placed as a
separate agency in the Department of Commerce and Labor. When this
department was split into the respective departments of Commerce
and of Labor in 1913, the bureau was retained by the Department of
Labor where it remained until transferred to the Federal Security
Agency in 1946. In 1920 a close associate of Lillian Wald and a
strong supporter of the bureau expressed her gratitude over the
bureau's placement in the Department of Labor: "Had the Bureau
in its inception been limited by the outlook either of a department
of health or a department of education - assuming that both of these
departments were led by the wisest and most generous of statesmen -
there would of necessity have been lost much of the very fine work
of the division. Its activities have traversed many fields and in
particular they have thrown great light on the so-called borderland
of science, the undefined region which has belonged assuredly to
none. Under its present direction in the Department of Labor, the
department which par excellence is concerned with broad considera-
tions of human well-being, the Bureau has had the untrammled right
freely to serve the Nation."^ Granted the organic and integrative
approach of the bureau to its problems it, nevertheless, has had

January 24, 1920.
several struggles to keep the health aspects of its program from
being transferred to the United States Public Health Service — but
more of that later.

The Sheppard-Towner Act, 1922:

The Act establishing the Children's Bureau reads in part, "That
said Bureau shall investigate and report... upon all matters pertain-
ing 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, orphanages, juvenile courts, de-
sertion, dangerous occupations, accidents and diseases of children,
employment, legislation affecting children in the several States and
Territories." It will be noted that the bureau was originally es-
tablished solely to investigate and report, but as it gained in ex-
perience and had assembled and trained a small but highly technical
staff who had become experts in the problems of maternal and child
welfare, it became the natural agency to be entrusted with new pro-
grams of this nature. Such was the case when the bureau was de-
signated by Congress as the agency to administer the first Federal
Child-Labor Law effective from 1917 to 1918 and subsequently
declared unconstitutional by the Supreme Court. The later programs
that expanded the original functions of the bureau, each new pro-
gram being larger than the previous ones, were the Federal Matern-
nity and Infancy Act in effect from 1922 to 1929, popularly known
as the Sheppard-Towner Act, the maternal and child welfare pro-
visions of Title V of the Social Security Act passed in 1935, and
the present Emergency Maternity and Infant Care program which grew
out of the war emergency and made possible through a very liberal
interpretation of Title V by Congress.

37 Stat. 79 (1912).
Thus the expanding functions of the bureau have reflected the emerging needs in a dynamic society and the attempts to meet them. It is a truism to state that no government agency exists in a vacuum; it is too frequently forgotten that a government agency is an effect and not a cause of attempts to cope with social problems.

During the first nine years of the bureau's existence from 1912 to 1921, it laid a firm foundation of scientific research and dissemination of information to the people of the country. These services have been maintained and even expanded while the bureau undertook the administration of new programs. The early studies of infant mortality, which placed major emphasis on income, housing, employment of the mother, and other factors affecting the infant death rate, were made under the direction of a staff which included physicians, social workers, and statisticians. Baby week in 1916 and 1917, Children's Year in 1918, and the White House Conference of 1919 all brought out important facts as to maternal and child health in this country and added to the data accumulated by the bureau. Evidence gathered by the bureau of conditions under which children were employed plus the campaigning by the National Child Labor Committee led to the passage of the Federal Child Labor Law in 1916. The studies concerning maternal and infant care in rural areas and other sources of data provided the evidence justifying the passage of the Sheppard-Towner Act in 1921, which was a grants-in-aid to states to encourage greater interest and action in maternal and child welfare programs.

The provisions embodied in this act were first recommended by Miss Lathrop in her fifth annual report in 1917. It was based upon the principle of extension of local maternal and child health services through the leadership and assistance of state health
agencies receiving grants of funds from the federal government, these grants being matched by the states. Thus precedents developed extensively in the improvement of agriculture through Federal aid were applied to the promotion of maternal and child health the same as the research and reporting functions outlined in the Act of 1912 creating the Children's Bureau had been suggested by similar work in the Department of Agriculture. This is an excellent illustration of how precedents established in one field of endeavor can very easily and effectively be applied to other fields. Law making bodies are much more likely to authorize an activity if it or something like it has been done before.

The expansion of the functions of the bureau from investigating and reporting to administrative and supervisory functions in health matters caused bitter controversy. The hearings on the bills introduced in Congress in 1919, 1920, and 1921 were contests between opposing factions, with the Congressional committee members conducting the hearings caught between the verbal cross-fire. It is of interest to note that many of the issues discussed and the general tenor of the hearings with respect to the Sheppard-Towner Bill are practically the same as for the later EMIC proposals. In fact, if names of people and events were deleted from the records of the hearings during the two periods, 22 years apart, they could hardly be differentiated from each other.

The opponents of the Sheppard-Towner Bill argued that its adoption would be another step toward "socialized medicine;" it would provide the "entering wedge;" too much power would be centralized in Washington; States' rights would be violated. The proponents countered by pointing out that no state would be forced to accept grants-in-aid; no physician would be forced to participate; the actual administration of the program would be left entirely to the States, the Children's Bureau serving only in a consultative and supervisory capacity; no medical services, as such, would be rendered by the agency; state and local initiative would be strengthened instead of weakened by grants-in-aid. The opponents appearing at the hearings were individual physicians, representatives of the American Medical Association, the Woman Patriot (official organ of the National Association Opposed to Woman Suffrage), Sentinels of the Republic, and the Catholic women's organization in Massachusetts. The proponents appearing were from various women's organizations, child welfare organizations, the president of the American Public Health Association, and representatives of other organizations.

The inter-agency controversy between the United States Public Health Service and the Children's Bureau reached an acute stage in the hearings on the bill. There was some testimony favoring the administration of the provisions of the bill by the Public Health Service instead of the Children's Bureau. The question was asked whether the bill was chiefly concerned with health or with general child welfare; if with health the Public Health Service should be designated as the administrative agency; if with general child welfare the Children's Bureau would be the logical choice. The competition between the two agencies was brought to a temporary end.
in a last minute conference called by the respective cabinet chiefs (Treasury and Labor), as a result of which the Children's Bureau retained control over the maternal and child health program. In this regard it is the opinion of a student of the grants-in-aid principle that the bureau gained control over this program "by right of discovery and occupation and that the Public Health Service had been derelict in not promoting this type of work with sufficient vigor to maintain its belated claim to jurisdiction." This quotation deserves reading and re-reading by public health officials today. When the subject of a governmental health plan arises, one of the first concerns is the agency of administration. Control "by right of occupation" is a phenomenon that repeats itself many, many times in governmental activities.

A further reason for the bureau's retention of this program was expressed by an authority on federal health activities: "The Children's Bureau is based not only upon the administrative theory of the special population group, but also upon the political conviction held by large groups of women and social workers that child and maternal welfare problems were before its creation suffering from comparative neglect, and since its creation have obtained at the hands of its essentially feminine personnel a sympathetic and progressive development." In the evolution of the function of the bureau, the health aspects of its program have become its most important features, hence the inevitable clash with another government agency dealing exclusively with health matters.

10 Leigh, op. cit. p. 528.
The Sheppard-Towner Act set the pattern for later maternal and child health programs. Its chief features were: (1) Federal financial aid to the states, (2) administration by the Children's Bureau, (3) the application of grants-in-aid to the problem of reducing maternal and infant mortality and its use in protecting the health of mothers and infants, and (4) the vesting in the states of authority to initiate and to administer plans, subject to approval by the Federal Board of Maternity and Infant Hygiene. Further, the Federal government granted $1,240,000 a year to the Children's Bureau to be used in grants-in-aid to states, and $50,000 a year for Federal administration. The states could accept or reject aid as they saw fit, but in order to secure the benefits of the act each state legislature was obliged to accept its general provisions, and designate a state administrative agency. In the actual initiation and operation of the state plans each state had to submit descriptions of programs to the Federal Board of Maternal and Infant Hygiene for approval and make reports of operations. The board was composed of the chief of the Children's Bureau, the Surgeon General of the Public Health Service, and the Commissioner of Education, the chairman being chosen by the board from among its own membership. The chief of the Children's Bureau acted as chairman for the duration of the act. The powers of the board consisted of approving or disapproving the state plans submitted, and of withholding Federal funds from any state whose program was not being operated as agreed upon between the state and the board. The duties vested in the Children's Bureau were the general administration of the act—formulating rules and regulations and consulting with the


Provided by the Maternal and Child Health Library, Georgetown University
states, -- certifying payments to the Secretary of the Treasury and making studies and investigations.

Thus, Congress authorized the first grants-in-aid program in the broad field of maternal and child health.* It is argued that the grants-in-aid principle lends itself to the American constitutional system because of the separation of state and federal functions and the taxing power of the federal government. Furthermore, "the grant system builds on and utilizes existing institutions to cope with national problems. Under it the states are welded into national machinery of sorts and the establishment of costly, parallel, direct federal services is made unnecessary. A virtue of no mean importance is that administrators in actual charge of operations remain amenable to local control. In that way the supposed formality, the regularity, and the cold-blooded efficiency of a national hierarchy is avoided." 12 When the Supreme Court of the United States declared the present Social Security Act constitutional, the grants-in-aid was given a firm, legal basis.

In the seven years of the program's existence the groundwork was laid for a national maternal and child health program. From 1912 to 1920, 32 states had established divisions or bureaus of child hygiene. From 1921, the year of the passage of the act, to 1923 an additional 15 states had created agencies. 13 It is difficult, if not impossible, to determine to what extent the act stimulated the states to create new child hygiene agencies. But it is of interest that the expansion of the functions of the Children's Bureau and the creation of state agencies of child hygiene go hand

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*The first grants-in-aid program for health was the short-lived Kahn-Chamberlain Act of 1917 to combat venereal diseases.

12 Key, op. cit., p. 383.


Provided by the Maternal and Child Health Library, Georgetown University
in hand. The federal and state activities in this field are part of the same context and it is reasonable to assume that this reflects the growing popular interest in maternal and child welfare. The Children's Bureau program, therefore, can be given credit for the expansion of the work of the current maternal and child welfare projects carried on by the states.

Under the Sheppard-Towner Act 45 states submitted programs to the Federal government for approval. Three states, Illinois, Massachusetts, and Connecticut, refused to avail themselves of Federal funds. They did have their own programs, however. The staff immediately added to the bureau for the administration of the act consisted of a medical director, a public health nurse, an accountant, a secretary, and a stenographer, but the bureau felt that this staff was insufficient for effective field work.14 Later more members were added.

In 1926 a bill was introduced in Congress to extend the Sheppard-Towner Act from five years to seven years. This also aroused vigorous debate. Opponents of the original act seemed to have assumed that it was a temporary measure to give the states a "lift", so to speak, until they could carry the full expenses of their own programs.15 The proponents of the bill contended that the state programs were still not strong enough to be continued by the states alone. Upon being asked how much time would be needed, of course no definite answers could be given. In any case, the act was extended for another two years, and efforts to continue its

14 U. S. Children's Bureau, Publication No. 137, op. cit., p. 27.
provisions beyond 1929 were to no avail. Following the expiration of the act, the legislatures in a few of the states increased their appropriations for maternal and child health, in some instances in an amount that exceeded the previous combined Federal and state funds. However, the net effect of the withdrawal of Federal aid to the states and the District of Columbia was that five states reported increases over amounts expended in 1928 and 35 reported decreases; nine reported no appropriation at all. Significantly, 22 of the states and Hawaii reported funds in 1934 which were less than 50 percent of those expended in 1928 under the act.

In its first comprehensive report of the operation of the Sheppard-Towner Act the Children's Bureau stated that, "In a few States where the initial work has not been outstandingly successful it is largely due to lack of understanding of the purposes and plans of the State program. In order that medical cooperation might be assured, a number of State plans definitely stipulated that the State health department should not undertake work in any county or community, even though a demand existed for it, until the project had been placed before and endorsed by the local or county medical society. Thus, the responsibility of fulfilling a recognized local need, demanded by the public, was placed entirely upon the local medical profession."

A sympathetic observer of the program who had interviewed many state health officers and directors of child hygiene divisions was of the opinion that the bureau adopted a "laissez-faire policy"

18 U. S. Children's Bureau, Publication No. 137, op. cit., p. 25.
in the administration of the act, a policy which naturally received widespread approval of the state officials cooperating in the program. He added that "no other federal law has been so consistently misrepresented, nor so frequently accused of making possible federal domination."19

Unsuccessful attempts were made in 1931 and 1932 to revive the Sheppard-Towner Act.20 Thereafter no further movement was made in this direction until the Social Security Act was adopted in 1935 with provisions for maternal and child health embodied in Title V.

It is difficult to assess the effect of the Sheppard-Towner Act on maternal and child health programs throughout the country, but it is true that a pattern of Federal-State administrative and fiscal relationships was established which was carried, for good or for ill, into the administration of the maternal and child health program inaugurated by the Social Security Act and the later expansion of this program to include the EMIC Program.

The Social Security Act, 1935:

With the adoption of the Social Security Act in 1935 the Children's Bureau regained and added to the functions it lost when the Sheppard-Towner Act was discontinued in 1929. From 1929 to 1935 the bureau continued its research program and promotional work in the general field of maternal and child welfare. After the adoption of the Social Security Act direct administrative relations with the states were again established.

The Children's Bureau was given responsibility for the administration of Title V of the Social Security Act which provided for three programs of maternal and child welfare: (1) maternal and child health, (2) crippled children, and (3) child welfare services. By statute the Bureau was given an annual budget of $8,170,000 for grants-in-aid, exclusive of administration, allocated as follows: maternal and child health, $3,820,000; crippled children, $2,850,000; and child welfare services, $1,500,000.

The beneficiaries of the programs are theoretically all mothers and children in the states who wish to avail themselves of the services. The usual services provided under maternal and child health by the state are: (1) to develop maternal and child health services in district or county public health units and in areas without full-time public health services; (2) to develop high standards of services in the maternal and child-health field; (3) to enlist the cooperation of members of the medical and allied professions and of community groups in extending state-wide facilities for continuous medical and nursing care and health supervision through maternity, infancy, and childhood, and in maintaining high standards of care; and (4) through health education programs conducted by physicians, dentists, nurses, and nutritionists to inform parents and children of the practices essential for health.21

The crippled children's program deals with medical services and rehabilitation for crippled children, and the child welfare program with foster home care, juvenile delinquency, and many other child welfare problems.

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The basis of allocation to the states varied with each type of program. For maternal and child-health each state was entitled to $20,000. The remaining sum of $1,300,000 called "Fund A" was to be shared among the states on the basis of the number of live births in each state in relation to the total number of live births in the United States with the states matching their requests by 50 percent. That is, if the Children's Bureau provided $20,000 for a program in a certain state that state must match that sum by $20,000. Another sum of $980,000 was allocated to the states on the basis of financial need and the number of live births in the state. No matching of funds was necessary. This was the "B Fund" to be described later since it was this money with which the emergency program that preceded EMIC was started.

For crippled children $20,000 was granted to each state, and the remaining sum of $1,330,000 was allotted according to the need of the state as determined by its number of crippled children in need of services and the cost of furnishing such services.*

Lastly, each state was granted $10,000 for child welfare services and the remainder, $990,000, went to the states on the basis of plans submitted and the proportion of the population that was rural.

In 1939 the total appropriation to the Children's Bureau for grants-in-aid was increased from $2,170,000 to $11,000,000. The maternal and child-health program received an additional $2,000,000 divided equally between its matched and unmatched funds, the crippled children's program received an increase of $1,020,000, and the child welfare program $10,000. In 1946 Congress amended Title V again.

*There was no B Fund under this program until 1939.
providing for an over-all increase in appropriations from $11,000,000 to $22,000,000 plus an increase in the amount for administrative expenses.

Within 10 months after the appropriations under the Social Security Act became available on February 1, 1936 all the 48 states, the District of Columbia, Alaska, and Hawaii had submitted plans for maternal and child-health services for approval by the Children's Bureau and had qualified for grants. The total grants to states for maternal and child-health services increased from almost $3,000,000 in 1937 to $5,820,000 in 1941, the latter being the entire amount appropriated by Congress.

The control that the Children's Bureau has over the programs is vested primarily in its power to withhold funds from the states if they do not submit plans for programs which meet the requirements set up by the bureau in accordance with the conditions of the Social Security Act or if a state does not maintain the program satisfactorily once it is established.

During 1942 when the problem of the care of the wives and infants of servicemen first arose, more than 160,000 mothers received prenatal care under the maternal and child-health program. About 185,000 babies and some 300,000 young children were given health examinations at medical conferences; more than 1,600,000 school-age children were examined by physicians; over 2,000,000 children were vaccinated against smallpox, and more than 1,600,000 were immunized against diphtheria, and approximately 1,500,000 mothers and children were given care by public health nurses. The report for 1942 shows the progress that was being made with grants-in-aid from the Children's Bureau matched by state funds.
The maternal and child-health program is administered on the state level by divisions of maternal and child-health in state departments of health; the crippled children's program is administered in 30 states by the health departments and in the other states by commissions, welfare departments, or departments of education; and the child welfare services are administered by state departments of welfare. The chief concern of this study is with the maternal and child-health and crippled children's programs administered by state health departments because it was within this framework that the EMIC program developed.

Until the recent reorganization of health and welfare services in the Federal government, the Children's Bureau was in the Department of Labor, the chief of the bureau being directly responsible to the Secretary of Labor, who in turn is a member of the President's cabinet and directly responsible to him. Within the Children's Bureau are the various administrative divisions dealing with the several programs among which is the division of health services. This division is headed by a physician, usually an obstetrician or pediatrician. The staff of the health division recommends and the chief of the Children's Bureau approves the state plans submitted for maternal and child-health services.

The maternal and child-health program is administered through the divisions of maternal and child-health in the state health departments, the heads of these divisions always being physicians who are usually specialists in maternal and child-health problems. The directors of the divisions of maternal and child-health are state employees directly responsible to the directors of health of the state health departments.
The country is divided into eight regional offices each staffed by medical, nursing, medical social work, and nutrition consultants to serve as liaison officers and as advisors to the state agencies. These offices are headed by medical directors who are usually pediatricians to interpret the Children's Bureau policies to the states, and to consult in medical and administrative problems.

The Children's Bureau has had a specialist in medical administration during the past few years to consult with the states on administrative techniques, record keeping, and other matters.  

On the federal level the Children's Bureau has advisory committees for each of its major programs, and also calls in other groups when the occasion warrants it. The Advisory Committee on Maternal and Child-Health Services is a permanent committee for the maternal and child-health program. This committee is composed of 58 members from the fields of general medicine, obstetrics, pediatrics, psychiatry, public health administration, dentistry, nutrition, public health nursing, and hospital administration. Its powers are purely advisory; its decisions are not binding on the Children's Bureau. From this committee two subcommittees are appointed, the Subcommittee on Maternal Health and the Subcommittee on Child-Health.

When the problem of the maternity and infant care of the wives and infants of servicemen came before Congress in 1943 the Children's Bureau seemed the natural federal agency to be entrusted with a program of this nature. In the federal office it had a

*Early in 1947 the bureau placed a medical administrative consultant in each of the regional offices.
staff trained and experienced in the problems of maternal and infant health and crippled children's services; in each of the state departments of health the bureau had worked through divisions of maternal and child-health since 1936, which agencies were the only ones in the states with experience and training in this field; the bureau could legally, as was proven later, expand the interpretation of Title V of the Social Security Act to include the program for wives and infants of servicemen; and the bureau could finance the beginning of the program by resorting to fund 3 which could be allocated to the states on the basis of financial need. After fund 3 was exhausted, Congress had the power to authorize a deficiency appropriation even though the Social Security Act had established a statutory limit. Such action was subject to a point of order, but during the war period emergency appropriations were made without points of order being raised. This was an emergency, and actions to meet emergencies do not usually wait for legal niceties.

Thus, from 1912, when the Children's Bureau was established, to 1942 the groundwork was unwittingly laid for the administration of the Emergency Maternity and Infant Care program for the wives and infants of servicemen. The strengths and weaknesses of the administration of the maternal and child-health and crippled children's program would very readily become apparent in the administration of the new program.
CHAPTER III

THE ESTABLISHMENT OF THE EMIC PROGRAM

The Problem Emerges, 1941-1942:

In October, 1940 the first compulsory military training act in peacetime was passed by Congress. From that time until the Japanese attack on Pearl Harbor on December 7, 1941, the military forces of the country grew constantly. Following Pearl Harbor and the declaration of war on Japan and Germany, the number of men in the armed forces increased to approximately 12 million.

By the latter part of 1941 the number of wives who followed their husbands to many parts of the country increased to a point where the areas around military camps and installations became badly congested, taxing the service facilities of the camps and the surrounding communities beyond their capacity. To many of these women children were born under sub-standard conditions because of inadequate funds to procure the services of the medical personnel and facilities that existed.

In a very short time the acute nature of the problem became obvious. The needs were easily definable, the people requiring assistance were easily identified, and the particular geographical areas where the greatest needs existed could be delineated. The needs were for financial assistance and the provision of services for obstetrical, hospital, and pediatric care. The persons involved were the wives and infants of servicemen, and the areas in which their needs attracted attention were around military training camps and installations. It was this attention, first concentrated about the military areas, that led to action involving the wives and dependents of servicemen throughout the nation.
The first direct appeal for help came from Ft. Lewis, Washington in August, 1941, after the medical staff in the camp hospitals found itself overwhelmed with the problem of providing maternity services for the wives of servicemen stationed at the camp. The military authorities turned to the Washington State Department of Health for assistance. The division of maternal and child health in the department had around $14,000 of unexpended funds from the "B fund" which, as previously described, was an outright Federal grant to the state on the basis of need. 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 women in the area were registered for care.¹

As early as March 27, 1942 the Committee on Maternal and Child-Health of the Association of State and Territorial Health Officers considering the above experience recommended "that state health agencies develop plans to finance from MCH (maternal and child-health) funds the medical and hospital care needed by wives and children of men in military service unable to purchase such care, and to make more readily available medical and nursing services for mothers and children in critical areas."²

In the light of this early experience and action it is dis-comfortingly significant that in seven of the eight states in

²U.S. Children's Bureau. Recommendations of the Committee on Maternal and Child Health of the State and Territorial Health Officers, March 27, 1942. 2p. (mimeographed)
which the study of EMIC was made, it was reported that there were no direct appeals for assistance to the state health departments from servicemen or their wives or from agencies which had occasion to handle hardship cases among them, such as Red Cross chapters and public welfare agencies. Yet, American Red Cross representatives at 240 Army posts reported that in the one month from July 15 to August 15, 1942, 3,262 servicemen requested help in securing maternity care for their wives; 39 percent of these were for assistance in obtaining care for wives living near the Army post, and 61 percent were requests for assistance in obtaining care for wives living in another state. Furthermore, the American Red Cross reported that it received 2,601 requests from wives of men in service for help in obtaining maternity care or care for their sick children during the month of August, 1942. This report was based on a study of a 10 percent cross-section of the chapters in 46 states.\(^3\) Investigations were also made by the Children's Bureau in the defense areas and great need for assistance was found.

Not until the EMIC program was launched officially in March, 1943, and publicity concerning it reached the newspapers did an avalanche of demand descend upon the state departments of health. This effect is too often ascribed to an artificially stimulated demand for a program of this nature by the Children's Bureau rather than to a real demand based upon a real need. Though the appeal for assistance from Ft. Lewis, Washington, was direct and insistent, and similar assistance was necessary around other military training camps and installations, it is frequently contended that the acute conditions in these areas could have been

\(^3\)Hearings, February 11, 1943. op. cit., p. 325.
alleviated without eventually involving every health department in the United States and the majority of physicians and hospitals. Neither argument carries weight in the face of the Red Cross reports and the later support of the American Legion, based upon the experience during and following World War I when its members struggled with problems of paying for obstetrical care. The accelerating demand for obstetrical and pediatric care after the EMIC program was launched should indicate beyond a reasonable doubt that real need existed.

Rarely do unorganized potential beneficiaries of any social program make their desires and needs known to government agencies directly. Usually needs are recognized by individuals, groups, and agencies which are in a position to identify them and marshall the community resources. The fact that state health departments were not approached by servicemen and their wives indicates only one thing with certainty -- the lack of an association in the public mind between the need for maternal and child care and the functions of a division of maternal and child health. After the EMIC program was launched the departments of health became much more real to servicemen and their wives since they then had a government agency to which they could make their needs known and from which they could expect help.

Such, in brief, is the story of the beginning and the recognition of a social problem which aroused the interest of the general public, government agencies, and Congress. Once the problem was recognized the next steps were concerned with its solution.
Appeals to Congress 1943 - 1946:

By July, 1942 the program in the state of Washington had attracted the attention of divisions of maternal and child health in other state health departments. When the Federal allocations for the fiscal year beginning July 1, 1942 were made, 27 states had received approval to use B funds to provide maternity, obstetrical, hospital, and pediatric care for the wives and infants of servicemen. Of the total sum of B fund, amounting to $1,960,000, the Children's Bureau allocated $193,000 for this program. Actually, however, the bureau had received requests totalling $544,000 from 38 state health departments.

Later, the Children's Bureau dug deeper into the B fund during the six months period of July to December, 1942, and allotted $319,295. In addition eight state health departments were able to use unexpended balances in the amount of $70,882. Thus, a total of $390,177 was made available. The Children's Bureau felt that this was the maximum amount possible without seriously interrupting existing state and local maternal and child health services. Since the B fund would be exhausted long before the end of the fiscal year ending in June, 1943, the Children's Bureau believed that $1,817,200 would be necessary to supplement the exhausted B funds until June 30, 1943.

On February 1, 1943 Congress received a recommendation from the President for $1,200,000 instead of the $1,817,200 desired by the Children's Bureau. The request was referred to the Committee on Appropriations of the House of Representatives two days later and it became part of the First Deficiency Appropriation

\[1\text{Ibid., p. 319.}
\[\text{See appendix for chronological table of appropriations for BMIC.}
Bill of 1943, H.R.1975. The Subcommittee of the Committee on Appropriations held hearing on the bill dealing with the request for funds by the Children's Bureau on February 11, 1943. Miss Katharine F. Lenroot, Chief of the Children's Bureau, and Dr. Martha L. Eliot, Associate Chief, were present to justify the request for additional funds.

The budget requests, the hearings, and Congressional actions are presented in some detail. In the Federal government the usual procedure for requesting funds is as follows: The government agency submits an estimate of need to the Bureau of the Budget; the bureau approves, rejects, or modifies the amount requested; the amount thus recommended is transmitted to the President for his approval, who, in turn, submits the budget request to Congress. Thus are seen examples of the legislative process, examples that are healthy antidotes to the dangerously prevalent concept of the government agencies and Congress as centers of political chess where few moves are made on a basis of merit. They serve, too, as examples of the manner in which public servants are required to fulfill their responsibilities and justify their actions.

Miss Lenroot stated at the hearing that up to February 9, 1943 requests and estimates from state health departments for the period January to June, 1943, totalled $2,291,492. 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 of the cases for which application has been made. Exact data on waiting lists are not available from all States, but it is known that one State had

**It should be noted that all bills dealing with appropriations must originate in the House.**
in December 1942, a waiting list of 300, another of 400. Still another is receiving applications at the rate of 12 a day and estimates an increase to 20 a day shortly. In this State funds are exhausted. Another State is receiving applications at the rate of 25 a week but reports that funds are exhausted. Many State health agencies are not accepting all requests for care since they know they cannot care for them with existing funds.6

The members of the Subcommittee apparently did not question the need for additional funds since the discussion turned quickly to the details of administration and finance. Miss Lenroot explained that the states would not be expected to provide funds: their contribution would be the existing administrative machinery in the divisions of maternal and child health in the states.6

The chairman of the subcommittee expressed some concern as to whether or not the program was a continuation of an already established 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." Dr. Eliot answered: "Yes."7

The chairman wished to know the requirements specified by the Children's Bureau of a state department of health before a program is approved. The requirements were expressed in the following testimony:

"Acceptance of cases regardless of legal residence, the establishment of methods of authorization for medical or hospital care, methods of referral of cases to public health nursing and

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5 Ibid, p. 319
6 Ibid, p. 321
7 Ibid, p. 323
social services as needed, the establishment of fixed rates of reimbursement for services rendered under the plan, safeguards of the quality of medical and hospital care.

"Grants-in-aid will be made quarterly to the States on the basis of (1) current experience in each State with respect to the number of birth certificates issued showing the father to be in military service, (2) the cost of the service per case within limits based on average cost of care for the area, and (3) the number of authorizations per month."8

With the information as given to this point, representative Wigglesworth, Massachusetts, inquired:9

Mr. Wigglesworth: What persons in a given State were eligible to similar medical care or help through your funds before you started this new project?

Miss Lenroot: There were in certain counties in certain States demonstration projects...

Mr. Wigglesworth: Haven't you had a maternity and child-health program?

Miss Lenroot: Our maternal and child-health program in the main was not used for hospital costs and medical care at the time of confinement. It is used for the cost of prenatal care and postnatal supervision and nursing care.

Mr. Wigglesworth: What were the conditions for prenatal and postnatal care?

Miss Lenroot: Prenatal and postnatal care were available as part of the general public-health program without qualifications as to indigency.

8 Ibid, p. 324
9 Ibid, p. 327
Mr. Wigglesworth: Wouldn't a girl whether she was a soldier's wife or not be eligible to either program?

Miss Lenroot: She would be eligible to prenatal and postnatal care.

Mr. Wigglesworth: Why do you want this new program?

Dr. Eliot: Because the funds that have been available so far to the States, and the State and local funds were not adequate for the States to set up programs of obstetric care, paying the doctor and the hospital for care. In order to do that more funds are needed.

Mr. Wigglesworth: Haven't you had that all along? That is what my question is directed to.

Dr. Eliot: Not obstetric and hospital care at confinement; only prenatal care by doctors and nurses, which costs much less than delivery care.

Mr. Wigglesworth: And I thought postnatal care was included there also.

Dr. Eliot: Yes; postnatal care also.

Miss Lenroot: That would be nurse's visits to a clinic 6 weeks after delivery.

Dr. Eliot: That is right.

Miss Lenroot: But the major cost, you see, is the care of the mother during the 10-day to 2-week period around the time of the birth of the baby either in the hospital or at home and funds have not been available for that except for a few demonstrations.

Dr. Eliot: Of course, there is a great need for a broad program.

*Miss Lenroot undoubtedly intended to say "patient's" instead of "nurse's".*
Mr. Wigglesworth: This program is open to anybody regardless of financial position and is open to any State without a cent's contribution by any State?

Dr. Eliot: The basic program that the States are now providing is the foundation for this program. A considerable proportion of the cost of this is provided by the States and localities.

Despite the seemingly favorable response by the members of the Subcommittee in the hearing on the request for $1,200,000 submitted by the Children's Bureau, the Committee on Appropriations in House Report No. 170 on February 24, 1943 denied it. The need for the program was not questioned, but there were certain technicalities which the Committee members felt were serious enough to block even an emergency measure. They were:

1. Basic enabling legislation should be enacted for a program of this nature. The Committee felt that the proposal "needs more consideration than can be given it by merely dealing with a sum of money in an urgent appropriation bill." It was felt that some authority existed in the Social Security Act, "but 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." (2) The other issue was the "lack of financial ability as a prerequisite to the benefits."

When the Deficiency Appropriation Bill reached the floor of the House on February 26, Mr. Keefe, Wisconsin, attempted to put the $1,200,000 back in the bill rejected by the Committee on Appropriations. Mr. Starnes, Alabama, opposed the amendment.

10H.R. Report 170 p. 6
11CONGRESSIONAL RECORD, 89:1405 February 26, 1943
on a point of order since he thought that the Committee was neither a legislative nor policy making Committee. He saw no legislative authority for the appropriation, but he offered to help draft the necessary enabling legislation. Mr. Keefe introduced an enabling law, H.R.2041, but it died in Committee.

In any case the First Deficiency Appropriation Bill for 1943, H.R.1975, passed the House and was referred to the Senate Committee on Appropriations minus the request of the Children's Bureau. On March 2, 1943 the Subcommittee held a hearing on the section dealing with the Children's Bureau request. Miss Lenroot and Dr. Eliot appeared again to justify their request and attempt to have it put back in the bill. Secretary of Labor Perkins also attended the hearing to lend her support.

The members of the Senate Subcommittee were concerned with the same issues as the Subcommittee of the House, namely, whether or not it was a new program, that it was entirely a federally financed program, and that it provided no means test. Miss Lenroot and Dr. Eliot repeated the assertions they had made at the hearing before the Subcommittee of the House as to the legality of the program. Senator McCarran, Nevada, stated: "This item itself, however, as it comes before this Committee and as it came before the House Committee, is a new activity." Miss Lenroot answered: "No, Senator, it is not a new activity; but it is an item that was felt by the House Committee not to be covered by basic legislation. Although the amount of money to be appropriated was in excess of that authorized in Title V, Pt. I, of the Social Security Act, the activity is covered by the legislative authority under

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12Ibid., p. 1408
Title V, part 1. Miss Lenroot testified further that after the exhaustion of the $1,200,000 requested in the present deficiency appropriations bill the bureau would need an estimated $6,000,000 to carry the program for a full year.

As of March, 1943 Miss Lenroot reported that 28 states had approved plans under which they were providing this special service, one more since the hearing before the House committee in February. However, 10 of these states had exhausted their funds, and in a number of other states the funds would be exhausted very shortly. "So, if additional funds are not made available, the programs will have to be discontinued in the 28 states where they are now in operation, and no additional states will be able to set up their programs." Dr. Eliot added that "The State health department would organize the program if it had funds. They are not asking for any administrative funds in this picture at all; they are asking only for the hospitalization and medical care of the patient."

Presented with such an accomplished fact the senators were placed under a weighty responsibility if they should insist on rejecting the Children's Bureau request on a basis of technicality. In the discussion ensuing on the floor of the Senate on March 12 it was decided to amend the appropriations bill as submitted from the House and put back the $1,200,000 for the Children's Bureau.

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13 U.S. Senate, Committee on Appropriations, Hearings before a Subcommittee on the First Deficiency Appropriation Bill for 1943, 78th Congress, 1st Session. March 2, 1943. p. 122

14 Ibid., p. 125.

15 Ibid., p. 136.

In the joint House and Senate committee considering this bill on March 15 it was decided to permit the inclusion of the Children's Bureau request since, as reported by Representative Cannon, Missouri; there was no difference of opinion as to its merits. On the same day the House passed the bill as amended. Thus, on March 18 the First Deficiency Appropriation Bill for 1943 became Public Law 11. The Emergency Maternity and Infant Care program which had begun as an expansion of Title V of the Social Security Act now had the official sanction of Congress.

In summary: The chief issues of concern to the members of the Subcommittee were: (1) whether this was a new program or a continuation of one already established, (2) no contribution was required from the states other than administrative machinery, and (3) no means test would be applied. These represent a search for precedents. Even if the members of the Subcommittee were satisfied that the program was the expansion of one already in existence, they still had to wrestle with issues (2) and (3). Outright grants to states without state matching was at variance with the usual grants-in-aid pattern established by the Social Security Act in 1935. The absence of a means test to determine eligibility before persons are given assistance from public funds to which they have not contributed directly ran counter to long established public welfare traditions. The fact that these precedents were disregarded in the appropriation bill which became law indicated the emergency conditions under which Congress was working. Although these issues were ostensibly settled as far as Congress and the Children's Bureau were concerned they were not readily accepted by organized medicine in the application of the law. This will

---Congressional Record, 89:2063 March 15, 1943.
be noted when the responses of recipients of services, state health departments, physicians, and hospitals to the program are discussed.

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 EMIC fiscal year, July, 1943 through June, 1944. By the time it reached the Committee on Appropriations of the House of Representatives on April 13 the amount had been reduced to $4,800,000. The House committee cut this sum to $4,000,000 and it was included in the appropriations bill for 1944, H.R.2935. The Subcommittee of the Committee on Appropriations held a hearing at the Children's Bureau request. Miss Lenroot and Dr. Eliot represented the bureau.

Dr. Eliot stated that the original request of $6,000,000 was based on an estimate of at least 72,000 applications during the fiscal year at about $85 per case. It was presumed, however, that the total number of cases would be higher.

An issue from the previous hearing, the desirability of a means test, was raised again by the chairman of the Subcommittee, Representative Hare of South Carolina. He was still concerned about its omission in the original act, but he seemed to resolve the problem to his own satisfaction, saying: "I have the strong conviction that the regulations should limit these expenditures to those who are actually in need of this assistance, or put a definite limitation on as to the amount for each one, unless you are going to say this is a contribution to the family as an expression of gratitude to those in the armed forces who are actually offering their lives in the service. If you put it on
that basis, it is an entirely different proposition."\textsuperscript{18} Miss Lenroot answered: "I think we have to assume that that was the basis Congress put it on, because of the language of the act."\textsuperscript{19} This seemed to settle the issue of the means test as far as Congress was concerned, because the subject was not discussed by the members of that body again.

The exclusion of the means test was a logical development stemming from the philosophy and the activity of the Children's Bureau since its inception in 1912. This was perhaps particularly true when the bureau entered the health field in 1922. The bureau adopted the current public health philosophy of service to the entire community for the benefit of the entire community regardless of income. The inclusion of a means test in the EMIC program would have meant a reversal of a fundamental bureau policy. Furthermore, state health departments would have had to create new administrative machinery whereby the means test could be applied or else have had to work in cooperation with state welfare departments.

On June 14, 1943 the Committee on Appropriations of the House of Representatives recommended the sum of \$4,000,000 to cover the 4th, 5th, 6th, and 7th pay grades.* However, it was


\textsuperscript{19}Ibid.

*Army: Private; Private, lc; Corporal; Technician, 5th grade; Technician, 4th grade; Sergeant, 4th grade. Marine Corps: Private; Private, lc; Corporal; Sergeant, 4th grade; Assistant cook; Cook, 3c; Field cook; Field music; Field music, lc; Field music corporal; Field music sergeant; Steward's assistant, 3c, 2c, lc; Steward, 3c. Navy and Coast Guard: Apprentice seaman; Bugler, 2c, lc; Coxswain; Fireman, 2c, lc; Hospital apprentice, 2c, lc; Seaman, 2c, lc; Steward's mate, 2c, lc.
recommended that the Children's Bureau should render assistance where circumstances required to wives of men in the first three pay grades.\textsuperscript{20}

The committee also recommended a reduction of $28,000 of the $350,000 requested annually by the Children's Bureau for salaries and expenses in administering the maternal and child health, crippled children, and child welfare programs. The committee was of the opinion that these appropriations for the three programs "are in the same amounts as have been appropriated for the past 4 years. As the program progresses, it should be possible to reduce the amount necessary for administrative expenses."\textsuperscript{21} This naturally was of great concern to the Children's Bureau because it had undertaken the EMIC program without an increase in the general budget for administration. In the states the bureau had hoped that the state health departments would augment their budgets for administration from their own funds. It appears that the Committee on Appropriations had taken the statement of the Children's Bureau seriously when Miss Lenroot and Dr. Eliot stated in the hearings on the initial request for appropriations in March that funds for administration were not needed, at least not at that time.

On June 19, 1943 Miss Lenroot and Dr. Eliot appeared before the Subcommittee on Appropriations of the Senate asking for the $28,000 refused by the House Committee and also for the $300,000 deducted from the request of $4,800,000 for the EMIC program. The Senate committee was receptive to the Children's Bureau

request and recommended the restitution of both items in its report to the Senate on June 24, 1943.

The Senate committee recommended further that the following proviso be stricken from the bill: "Provided, that no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order, or regulation relating to care of obstetrical cases which discriminate between persons licensed under state law to practice obstetrics."\(^{22}\) Dr. Eliot had opposed this proviso as submitted by the House committee because it would jeopardize the power of the Children's Bureau to establish and maintain standards for persons rendering obstetric care.\(^{23}\) The Senate committee apparently agreed with her.

When the appropriations bill reached the House on July 1, 1943, the debate centered completely on whether or not the Children's Bureau might designate standards of practitioners participating in the EMIC program. The issue was Federal interference with state matters. Representative Keefe, Wisconsin, a strong supporter of EMIC, wished to leave the determination of standards to the states.\(^{24}\) The bill passed the House with the amendment leaving the matter to the states.

The next day, July 2, when the appropriations bill was in the Senate, chief attention was paid to the issue of whether or not the Children's Bureau should have the power to determine standards of practitioners in the states.\(^{25}\) Senator LaFollette, Wisconsin,


\(^{24}\)Congressional Record 89:7014-21 July 1, 1943.

\(^{25}\)Ibid., 89:7095-7103 July 2, 1943.
was in favor of Federal determination of standards. He saw no issues involving Federal-State rights.

The final outcome was in favor of state determination of standards when the appropriation bill, H.R.2935, became Public Law 135 on July 12, 1943. The appropriation for EMIC for the fiscal year 1944 was set at $4,400,000, $400,000 more than was originally recommended by the House committee and $400,000 less than that recommended by the Senate committee and the Bureau of the Budget, a perfect compromise. The bureau had requested $378,000 for the cost of administering its other programs including EMIC. The House committee reduced this by $28,000, but in the final appropriations bill the House and Senate committees had apparently compromised in a reduction of a little over $15,000. Thus the Children's Bureau received no funds for the administration of EMIC.

The Children's Bureau had $4,400,000 for EMIC grants to the states for the fiscal year, July, 1943 through June, 1944. By the middle of August, 1943 the bureau realized that it had greatly underestimated the demand for services. On August 25 the Children's Bureau reported need for a supplement of $20,076,235, with $622,799 or about 3 percent to be allotted to states for the cost of administration. In its recommendation to the Committee on Appropriations of the House of Representatives on September 16, the President reduced the original figure to $13,600,000 with nothing earmarked for state administration. Very quickly the House reported and passed a bill for the same amount on September 22, but the discussion in the hearings the previous day brought out pertinent issues.

At the hearings held before the Subcommittee of the Committee on Appropriations of the House 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 anticipated deliveries for care could apply for assistance. The actual experience of the first two months of the fiscal year indicates that about 50 percent of the eligible cases will apply for care."²⁶

Miss Lenroot continued that the request for $18,600,000 is to provide for 9 1/3 months. She felt she should have asked for $24,000,000 in June. In addition $33,000 was requested for administrative expenses of the Children's Bureau to offset the reduction of $15,000 suffered in the previous appropriation bill.

Up to this time the EMIC program had provided specified services to the wives and infants of servicemen instead of direct cash payments. The physicians and hospitals provided the services at established rates paid by EMIC funds through state departments of health. This procedure was of great concern to some physicians who preferred that the patient receive standardized cash allotments from EMIC funds leaving the financial settlement between physician and patient as was customary in private practice. The patient was to receive the allotment and arrange for her own care. In this way the physician would avoid dealing with a government agency.

The chairman of the subcommittee asked Miss Lenroot:

"Do you not think, Miss Lenroot, if it was understood that this was government assistance and was granted on a standardized plan, that a physician would bring upon himself considerable

criticism if he attempted to charge more, to charge the wife of some soldier fighting for his country in a distant land more than the standard price? Do you not think from the very nature of the situation it would be self-policing?"

Miss Lenroot: "I do not think it would be completely self-policing. I think perhaps there would be a number of instances where there would be an attempt to make an additional charge. Already there is evidence that physicians wish to be allowed to charge an additional fee and to negotiate these fees directly with the serviceman's wife.

"Moreover, I want to point out, if this policy were adopted, practically every wife would apply for care under the program. My view is that the amount required would be increased perhaps 85 or 90 percent if it were in the form of a cash allowance."27 The issue of cash allowance did not come up again during this hearing.

As the members of the subcommittee went more deeply into discussion of administrative details such as fees, rules and regulations, and forms and records they seemed to want to standardize the program all over the country -- this was especially true of fees to physicians. Representative Ludlow, Indiana, asked: "Now, everything connected with the Army and Navy is all tied in with the military effort and patriotic aspect, and everything connected with the Army and Navy, the soldiers, sailors, WACS and WAVES, is all standardized. What would be your thought, Miss Lenroot, about removing the variable factor from the allowances and, as Mr. Cannon (Missouri) I think, asked, make a standard allowance."28

27 Ibid., p. 471.
28 Ibid., p. 475.
Miss Lenroot: "We have canvassed that situation in the staff and I think the feeling in the staff is that it would greatly limit the program in some States; because there is a wide range of cost and it would probably be impossible to get enough doctors in some areas to cooperate in the program. We already have complaints; we have complaints from Members of Congress that the amount allowed for the doctor is so low that there are not enough doctors in the locality to serve the mothers." 29

It was brought out that the variation in fees to physicians for complete maternity care ranged in the states from $35 to $50, the latter figure being the maximum permitted by the Children's Bureau. Representative Harp, South Carolina, revealed that two physicians in his district refused to cooperate not because of the fee, "but upon the universal, abnormal, and what they considered unjustified number of requests and blanks giving information that they had to furnish in connection with the work. In other words, they said that the administrative work required by the Bureau was much more than the professional work required; therefore, they did not care to be bothered with it at any price." 30

At this point Dr. Eliot stated that requirements regarding reports from physicians are matters for the state to decide. However, the Children's Bureau needs to have reports as to the number of cases and the costs upon which the bureau can base its estimates and reports to Congress. The bureau has prepared suggested application forms to be used by the prospective patient, but no specific form has been required for the physician to report the care given.

29 Ibid.
30 Ibid.
After a discussion of the details of administration the hearing ended with some comments regarding the future implications of the program. Representative Lambertson, Kansas, was in full sympathy with the program, and thought it was serving a very good purpose. At the same time he saw how it could be easily enlarged. He said: "The only thing I can see about it is that it is drifting to socialized medicine and in the direction of the Wagner-Murray bill." Miss Lenroot answered: "This is a war program, and consideration of what happens next will have to be something else." Mr. Lambertson was not satisfied, however: "This is just an argument for the Wagner-Murray socialized medicine bill. It is just a leverage."

On September 22 the House passed the First Supplemental National Defense Appropriation Bill for 1944 with some change in the original law covering the ESSIC program. Families of men in grades 1, 2, and 3 were now eligible under any circumstances; grades 4, 5, 6, and 7 were now the only pay grades eligible. The House passed a request for $18,600,000 plus $20,000 for federal administration though the bureau had originally asked for $33,000. The committee reduced the amount by eliminating the proviso for two medical administrative consultants and assuming a somewhat shorter period of employment for auditors and clerks.

At the hearing before the Subcommittee of the Committee of Appropriations of the Senate on September 24, 1943 Miss Lenroot recommended that the Senate act on the basis of the appropriations made by the House. She was willing to accept the House provision

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3Ibid., p. 495
of $20,000 for administration, stating that it would be very difficult to get along without it.\(^\text{32}\)

As in the House committee fear of "socialized medicine" was expressed by Senator Holman, Oregon: "At the outset let me say that I am opposed to socialized medicine, and I don't know from my immediate knowledge whether that subject is involved in the present joint resolution or not. But when Congress, as it presumably will, makes this appropriation, are there restrictions on the use of the appropriation within the States which tend to Federal control of State practice?"

Miss Lunceford: "The plan is a state plan, and the state health agencies are responsible for developing the procedures under the plan. We have required certain conditions before we would approve a plan, inasmuch as the program is related to Title V, part l, of the Social Security Act, and the appropriation itself required that the Chief of the Children's Bureau should approve plans."\(^\text{33}\)

On October 1, 1943 H.J. Resolution 159 became Public Law 156, and the Children's Bureau received an increased appropriation of $18,620,000.

The fear of socialized medicine and the influence of the Wagner-Kurray Bill was the context in which the EMIC program emerged, but in spite of the fears expressed regarding its implications the program had the support of Congress and, as is seen, appropriations were made unstintingly. The war emergency


\(^\text{33}\)Ibid., p. 12.
stimulated action regardless of future implications. The program also had public support, some evidence of which was presented by Representative Bradley, Pennsylvania, who stated, when the appropriation for EMIC was discussed on the floor of the House: "I would like to make the observation that...it took the power of the public press, the American Legion, and the Veterans of Foreign Wars to compel the Republican Governor of Pennsylvania to make these benefits eligible to the servicemen of our state."34 Apparently the Governor had at first refused to let the state health department accept grants-in-aid from the Federal government for this purpose.

Not until the spring of 1944 did EMIC come up for consideration by Congress again. In the meantime the Children's Bureau, the state health departments, the physicians, the hospitals, and the wives and infants of servicemen were experiencing the full effects of the program. In the six months that had elapsed since the last appropriation the administrators, those who provided services, and the recipients of services had time to express their satisfaction or dissatisfaction. The succeeding Congressional hearings reflected the heightened feeling regarding the program.

The last appropriation bill for the EMIC program had been passed on October 1, 1943. In order to prepare for the fiscal year beginning July 1, 1944, the Children's Bureau indicated need for $24,100,000 plus $104,200 for Federal administration. Congress received a recommendation for $20,000,000 and $43,000 on January 10, 1944. On March 31 the President sent to Congress amendments to the proposed appropriation to include army aviation cadets, who had formerly been excluded, a recommendation that not more than

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34 Congressional Record 89:7943 September 22, 1943.
4 percent of the appropriation be allotted for state administration, and that the whole appropriation be made available immediately. It is apparent that the states were appealing for assistance to meet the costs of administration and that the case load was mounting so rapidly as to exhaust even the supplemental funds of $18,600,000 for the current fiscal year.

Instead of the proposal that the $20,000,000 be made available immediately it was decided to present a separate request for another supplement of $6,763,600 to carry through until July 1, 1944. The supplemental budget was reduced to $6,700,000 and submitted to Congress on April 29. In two weeks this amount was approved by both the House and the Senate without debate and became Public Law 303 on May 12, 1944. The House committee held a hearing but the Senate committee did not.

In the meantime the request for $20,000,000 for the next fiscal year was still under consideration and on April 20, 1944 the Children's Bureau expressed a desire for another supplement of that sum amounting to $22,810,400. Four percent of the total was for state administration. On April 29 Congress received a recommendation from the President for the round figure of $22,000,000.

On May 27, 1944, when House Bill No. 1599 was reported, the House committee had considered the two requests and the total sum acted upon was $42,800,000. Two percent was to be set aside for state administration and army aviation cadets were excluded. On June 1, 1944 the House passed the bill in this form. On June 13 the Senate committee reported the same amount but had stipulated 3 percent for administration and the inclusion of army aviation cadets. The bill was passed by the Senate in this form on June 15. Since the House and the Senate disagreed, committees of both houses
met and worked out a compromise of $2\frac{1}{2}$ percent for state administration and the inclusion of army aviation cadets. On June 28 the bill became Public Law 373. Congress also appropriated $43,000 to the Children's Bureau for Federal administration. Within 15 months, from March 18, 1943 to the above date, Congress had appropriated a total of $72,693,000 for the costs of maternal and pediatric care, $1,070,000 for state administration, and $63,000 for Federal administration.

The hearings conducted during the spring of 1944 represent the high point of discussion and debate in the Congressional appropriation committees. As will be seen the later hearings conducted on appropriation bills in 1945 and 1946 are quite routine and perfunctory. In 1944 there was much discussion; some issues were resolved and others were simply tolerated. The program was stabilizing.

Although the issue of cash or service benefits had been settled by Congress it remained a source of controversy within the medical profession. Representative Hare, South Carolina, Chairman of the Subcommittee on Appropriations said:

"I have been bombarded recently by communications from medical associations, here, there, and elsewhere, insisting that the next appropriation carry a provision to the effect that the allotment should be made directly to the beneficiary; that is, to the mother of the child, in order that she might use the funds as she may see fit."

Dr. Eliot again presented arguments against the cash benefit provision adding to her statement made during the previous hearing in September, 1943:

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Provided by the Maternal and Child Health Library, Georgetown University
"Furthermore, under a plan based on cash allowances there would be no way to assure the enlisted man that care, and the kind and amount of care needed, will be available for either his wife or his infant. In many cases a wife might not know what the community resources are and there would be no State or local public agency to which she could go to ask how to work out a plan for her own care or care of her baby.

"A plan for cash allotment to cover the costs of sickness in the case of the baby would be more unsatisfactory than in the case of maternity care for the wife of an enlisted man. The costs of care of individual sick infants would vary even more than the costs of maternity care and there would be no way to determine in advance the amount of a cash allotment necessary to meet these needs.

"The wife could have no assurance in advance that a cash allotment would meet the hospital and physician's bills that it may be necessary for her to incur. Nor could the hospital or doctor be sure that bills would be paid since they will not receive payment directly from an agency of government. The wife who is pressed for cash to meet living expenses might not be able to save the cash given her until the time comes to pay her doctor's and hospital bill. Hospitalization for these wives would not be assured to the extent it is under the present program that guarantees hospital payment.

"The board of trustees of the American Hospital Association on March 17, 1944, passed the following resolution: 'Resolved, That the American Hospital Association approve the system adopted by the Children's Bureau of the United States Department of Labor which provides for the purchase of hospital care by direct payment to hospitals on a cost basis. The American Hospital Association
further recommends that the Children's Bureau continue this policy in future purchases of hospital care...."36

Apparently the subcommittee was satisfied with the existing system of service benefits since the discussion turned to a maternity case in Georgia described by Representative Tarver from the same state. According to the Congressman the expectant mother, a wife of a serviceman, had delivered her child prematurely and therefore had not had an opportunity to apply for care under the EMIC program. She had fully intended to do so. Consequently her application was denied by the Georgia state health department because of a regulation that the prospective beneficiary must apply for care prior to the time care is to be given.

Representative Tarver was quite disturbed over this case; he felt the regulation was unjust since this mother could not give the notice because she had no reason to believe that she was going to be confined prematurely. As far as he knew there was no provision in the law passed by Congress requiring such a regulation. Therefore, as stated by him: "I do not know of any reason why your Bureau (speaking to Miss Lenroot and Dr. Eliot) should permit any state organization to set up any such requirement which would prevent according consideration in such a case, and the payment of the expenses of the mother that is prematurely confined. If there is anything that you or Miss Lenroot would care to say in exculpation of the procedure followed in that case, I would be glad to hear you."37

Dr. Eliot replied that the Children's Bureau had corresponded with the state health department regarding this particular case.

36 Ibid., p. 313.
37 Ibid., p. 314.
suggesting that an exception might be made to the rule that was set up in the state plan.

Mr. Tarver: "And the State health department refused to do that?"

Dr. Eliot: "The State health department replied to us that they were unable to find circumstances that would warrant approval of maternity care in this case. We believe, however, that the State health departments must, under the conditions of this program, take the responsibility for allowing a certain flexibility within the rules, and make exceptions where exceptions are desirable."

Mr. Tarver: "It ought not to be necessary to make any exceptions in that sort of case. You are spending Federal money. You are not spending State money. And when you permit a State health department to deny relief under the circumstances of a case such as I have detailed, you are certainly not acting according to the wishes of Congress in the appropriation of these funds.

"I do not understand how you can undertake to justify it at all; or why you try to put the responsibility on the State health department. It is an outrageous thing. I expect to discuss it on the floor, and I suggest, if you have anything further you want to say in excuse of this very flagrant misinterpretation of the law and the purposes of the law, I should be glad to have you say it for the record."\(^{38}\)

Other members of the subcommittee took up the discussion regarding Federal-State relationships. Representatives Keefe and Hare disagreed with Tarver as to the extent of control the Children's Bureau should have over the state departments of health. Representative Tarver, however, was so perturbed over the case\(^{38}\)
he knew about in Georgia that he thought the rules and regulations should be changed so that notice would not be required of the mother prior to the delivery of the child. Furthermore, he suggested: "I say that before you approve these regulations -- and it is your responsibility to approve the regulations -- you ought to require a provision not that it might be done, but that it shall be done." 39 Miss Lenroot replied to the subcommittee: "Mr. Chairman, I think we would be glad to be more strict in our requirements as to this point of discretion. I think all the plans permit the discretion. We have felt that it was a State-administered program and that, after the money was paid to the State, we had to leave to the State the responsibility as to individual cases, with such direction as we could give. However, we will be glad to make more stringent our requirements with reference to exceptional cases." 40 Also, during the discussion Miss Lenroot stated: "Mr. Chairman, may I say that if it is the desire of the committee and the Congress that we administer this as a Federal program, we are perfectly willing to do so." 41 Mr. Tarver did not see the problem as one of Federal or State administration, but as expressed by him, "The trouble comes not with granting to the States authority to administer the program under your supervision, but of the failure on your part, as I see it, to exercise proper discretion in the approval of State plans. wherever you approve a State plan which does not adequately care for situations...I have described, I think you are not exercising the proper supervisory discretion." 42 Later the rules and regulations were changed requiring state health departments

41 Ibid, p. 315.
42 Ibid.
to provide benefits to wives who failed to apply in time, if good reason is given.

During the same hearing the results of the proviso in the earlier EMIC appropriation law forbidding the Children's Bureau to determine standards for practitioners in obstetrics participating in the EMIC program in the state was discussed. The apparent reason for the proviso, as interpreted by the Attorney General of the United States and the Solicitor of the Department of Labor, was to limit the power of the Children's Bureau over the states. The states were to follow their own laws, many of them permitting practitioners other than doctors of medicine to practice obstetrics. It was found that some state health departments, acting under state laws giving such authority to the department, established their own standards excluding practitioners without a degree of doctor of medicine apparently in violation of the state licensing laws. The Children's Bureau was, of course, in no position to force the state health departments to comply with their state licensing laws when other state laws permitted the departments of health to establish their own standards. Representative Keefe, Wisconsin, stated that this completely nullified the intention of Congress which in his mind was to give all pregnant wives of servicemen access to any practitioner they desired, but he thought the Children's Bureau had acted correctly and in good faith. Since he had brought up the issue of States' rights in September as a reason for preventing the Children's Bureau from establishing standards in the states contrary to the state licensing laws he did not suggest that the law be changed so that state health departments would be forced by the Children's Bureau

43 Ibid., p. 343-350.
to comply with the laws of the state. He saw it as an example of the complexity of drafting laws so that they could be applied in the manner intended by the legislative body. The comments of Representatives Keefe and Tarver, both strong supporters of the EMIC program and of States' rights, indicate the difficulties that arise when philosophies must be transformed into the day-to-day realities of administration.

When hearings were held on the appropriation bill, H.R. 4899, for the fiscal year 1945 on April 27 and May 3 the members of the subcommittee brought up three problems with Miss Lenroot and Dr. Eliot: payments to physicians, payments to hospitals, and the extent of state control over the EMIC program. Representative Andersen, Minnesota, asked Miss Lenroot: "Do you feel the government is liberal or otherwise in its payments to hospitals and doctors that take care of a serviceman's wife and child?" Miss Lenroot thought that the hospital rate was entirely fair. As for physicians, "Our advisory committee, in the beginning, felt that for this program of service to men in the armed services and their families, it was fair to take a reasonable rate for the general practitioner, since the greatest percentage of the cases are handled by general practitioners; and that there would be difficulties in setting up a differential for specialists."

Representative Hare, chairman, had received the complaint that it was unfair to hospitals to receive only the average per diem cost of ward care for EMIC patients because these patients are almost all


maternity patients. It was stated that the actual cost per day for maternity cases is higher than for other cases. Miss Lenroot answered that she would be glad to consider per diem costs for maternity patients only if hospitals could give data and isolate the costs of maternity patients and general patients. Representative Hare continued: "If you are going to arrive at your hospital cost on the basis of the average cost per person to the hospital, why would it not be fair, then, to arrive at the medical fee, the physician's fee, on the basis of the average charge in that vicinity or in that community or in that hospital for births?" Dr. Eliot replied: "We recognize the fact that the charges made, the average charges made by general practitioners in different parts of the country, vary to some extent. In an original recommendation to the state agencies we said that it was their responsibility to set the medical fee, provided it did not exceed a certain maximum which we felt must be established as a ceiling; we thought we were recognizing that very differential in different parts of the country.

"I think you may be interested to know, in a recent conference with the Children's Bureau, that the Association of State Health Officers made a recommendation to the Bureau that the Bureau set a uniform fee for the country, and that a similar recommendation was made to us last September by the same body of State health officers." Representative Tarver of Georgia who previously had brought up the case of the woman in Georgia who was denied services under EMIC because of failure to apply for care in time, took the Children's

46 Ibid., p. 20.  
47 Ibid.  
48 Ibid.  

Provided by the Maternal and Child Health Library, Georgetown University
Bureau to task for not allowing the states any discretion in setting up their plans. He maintained: "So that instead of the states developing these plans, you develop the plans for the states and simply send them out instructions as to the type of plans which they must develop in order to receive approval of the Children's Bureau." Dr. Eliot countered by stating that the bureau outlines the administrative policy, but not the details of administration. Mr. Tarver apparently did not see the contradiction in his present viewpoint and the one he took on March 25, six weeks previously, when he thought that the bureau should have made the state health department of Georgia take care of an exceptional case. He wanted the bureau to prepare rules and regulations for every contingency which might arise in the states. Now he said: "And the idea you have state-administered plans and state discretion is fallacious; because, while that is nominally true and the language of the appropriations act would seem to so contemplate, as a matter of actuality you have instructed them in regard to the minutest detail of their program." Because of this he believed that the Children's Bureau and not the Georgia state health department was responsible for the manner in which the maternity care in his state was handled.

During the hearings on April 27 and May 3 testimony on the program was heard from the American Medical Association, a few state medical associations, the American Legion, women's organizations, and citizens' groups. The chief issues brought forward were direct cash allotment, low fees to physicians, "socialized medicine," and federal encroachment on the states.

50 Ibid., p. 455.
The organized medical profession was represented by the American Medical Association, the state medical associations of Minnesota, New York, New Jersey, Iowa, Louisiana, and California, and the Committee of Physicians for the Improvement of Medical Care. One physician represented himself. Other organizations represented were: State and Territorial Health Officers' Association, the National Child Welfare Division of the American Legion, the National Women's Christian Temperance Union, Congress of Women's Auxiliaries of the C.I.O., the National Women's Trade Union League of America, the National Board of the Young Women's Christian Association of America, and the National Congress of Parent's and Teachers.

Dr. W. W. Bauer testified for the American Medical Association and presented the resolution of the House of Delegates of that organization recommending that cash allotments be made to the expectant mother to defray the hospital and medical expense of her illness. He did not think the amount of the fees to physicians was an issue; adding that $75 or $100 or any other sum in excess of what is now specified would not solve the problem. He continued: "The problem in the mind of the medical profession is the problem of Federal control and a feeling that there is not sufficient opportunity for the program to be controlled in the States which it serves and where the needs of the locality are best known." If direct cash allotments were made to the wives of servicemen he did not believe physicians would charge any more for their services than the cash allotment given to the wives. His viewpoint, which was the viewpoint of the House of Delegates, was reiterated by representatives of the state societies.

51 Ibid., p. 516.
52 Ibid., p. 508.
Dr. William B. Thompson, representing the California State Medical Society, voiced the general opinion of the organized profession but he also added his own personal opinion. Excerpts from his testimony follow:

"It distresses us, practicing physicians, that we should be cleverly placed in the light of antagonism to a program beneficial to and needed by the wives and children of men fighting to preserve the free institutions of free America. We are not so opposed; it is the administration of the program that has aroused our ire."^{53}

"The plan of the Bureau was presented at a meeting of its advisory committee, but the committee was enjoined against offering any advice. Next, the plan was sent out to State boards of health, presumably for criticism, but any suggested modifications were ignored. It was then presented to Congress as a program worked out in cooperation with the medical profession. Not until the Bureau's press release flooded the country did the rank and file of medical men have any intimation of Federal participation in this service."^{54}

"We resent that implication that we would not give these dependents every necessary care, unless bound by contract to render certain specified services."^{55}

"I think that the medical association would be glad to work out a plan whereby those of us who are caring for these women would agree among ourselves to take care of the situation without signing a contract with a government hereon; that we could charge these women so much money, and that we would not exceed that amount."^{56}

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^{53} Ibid., p. 483.
^{54} Ibid.
^{55} Ibid., p. 489.
^{56} Ibid., p. 494.
Dr. Thompson stated that the physicians were losing money on the program; upon being asked what would be a fair price he answered: "$100 for specialists in a large city, $75 in a small city, and $50 to $60 for general practitioners in small towns." 57

After Dr. Thompson had spoken at length on the bad features of the rules and regulations Representative Keefe, Wisconsin, asked him what he would like to have eliminated in these regulations. His reply was: "I would like to have the contract eliminated." 58

Then Representative Thomas, Texas, queried: "Would the profession like to see the subsidy part of the program withdrawn too?" Dr. Thompson: "I think we would be very happy not to have any provision made for payment, although we feel that the dependent's circumstances are such that she probably needs it. But as far as we are concerned, that would free us from the Children's Bureau supervision, and we then would be left with our own conscience to deal with these people."

Mr. Thomas: "It is your opinion, then, that the medical profession as a whole would like to see the payment end of the program, or the subsidy end of it withdrawn, too; do I understand you to say that?"

Dr. Thompson: "That is my personal feeling about it, that we would be very happy to forget the fact that certain payments would be made by the government."

Mr. Thomas: "And put it right back as a purely contractual basis between the patient and the doctor?"

Dr. Thompson: "Yes, sir." 59

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57 Ibid., p. 499.
58 Ibid., p. 503.
59 Ibid., p. 507.
Dr. George C. Ruhland, Secretary of the State and Territorial Health Officers Association speaking for the state health officers complained of the lack of administrative funds. On behalf of the association he presented a resolution recommending that funds be provided each state and territorial department of health for administrative purposes, and also, that as far as possible a uniform fee for prenatal and obstetric service be established in all of the states and territories on a basis of $15 for prenatal and $35 for obstetric delivery services.60

The other organizations presented a solid front in support of the current program and in strong opposition to the direct cash allotment principle. Congress did not heed the request of organized medicine for the cash allotment and the appropriation bill for the EMIC program was passed leaving intact the principle of the service benefit. Thus ended the stormiest sessions through which the EMIC program passed either before this time or later.

On October 7, 1944 the Children's Bureau indicated it needed $44,189,500 for the fiscal year beginning on July 1, 1945. This amount was approved and sent to the Committee on Appropriations of the House of Representatives on January 9, 1945. Two and one-half percent or $1,104,700 was to be earmarked for the costs of state administration. The bill was approved by both houses and became law July 3, 1945 (Public Law No. 124, 1945.)

Compared with previous hearings, those held before the subcommittee on March 14, 1945 had reached a perfunctory stage. Broad philosophies and policies were no longer under discussion and only representatives of the Children's Bureau and members of the subcommittee were present. Miss Lenroot and Dr. Eliot reviewed

60Ibid., p. 486.
the program up to that time. In speaking of the general program of the Children's Bureau Miss Lenroot requested funds to increase the number of personnel in regional offices. It was the purpose of the bureau to place more responsibility upon regional staffs and thereby make progress toward the decentralization of the administration.61

The administrative problems in the EMIC program which came up for discussion were the provision of care for wives and children of discharged veterans and the possibility of the application for maternity care automatically serving as an application for the care of the expected child. Under existing regulations two applications had to be made.

Regarding the care of wives and children of discharged veterans Miss Lenroot stated that the Children's Bureau recommended to the states that "if the application for care were made and accepted before the husband was discharged from the service, care could be continued through completion. But we have not felt under the language of the act we were in position to authorize care after the discharge of the husband from service."62 This procedure was completely agreeable to the subcommittee. Representative Keefe thought the policy was important enough to publicize because of the increase in the discharge rate. He thought it should be discussed on the floor of the House so that all members of Congress would be advised of it.

62Tbid., p. 265.
The other administrative problem was raised by Representative Keefe. He did not see the need for the mother applying for care twice, once for herself during pregnancy, and the second time for her child after it has been born. He stated: "... it seems to me it is putting on unwarranted burden on the mother so that she has to go and fill out another application in case the baby is sick. Why isn't the original application sufficient to cover the care of the child for the year following delivery?"\(^6^3\) Dr. Eliot agreed that the original application should be sufficient. She mentioned that the matter had already been taken up with the Solicitor's Office for drafting.

In May, 1945 Germany capitulated to the Allies and in August, 1945 the Japanese surrendered to the Americans in the Pacific. These events naturally affected the future of the EMIC program since it was established to meet a war emergency. Before the Japanese surrender the national budget for the prosecution of the war for the fiscal year 1946 had been approved by Congress. With the war's end the President requested a review of the entire budget for possible reductions. The Subcommittee on Deficiency Appropriations of the House held hearings and the EMIC program came up for review on October 2, 1945.

Dr. Eliot stated that on the basis of new estimates the budget for the EMIC program could be reduced by $8,000,000. Representative Johnson, Oklahoma, was astonished at a government agency offering, on its own volition, to suggest that it's budget be reduced; "Mr. Chairman, do you mean to say that somebody has come up here voluntarily and said that their agency was a wartime agency and need not be continued in peacetime? It is most unusual for

\(^6^3\)Ibid., p. 271.
anyone to appear before this Committee and make such a statement.

"Do I understand from the witness that you have voluntarily returned money, and ask that it not be continued for this service?"

Dr. Eliot: "In response to that question, I would like to say that the Children's Bureau has accepted the fact that this is a wartime service. We realize that it has been a very great service to the wives and infants of servicemen in this country. We also appreciate very fully that in peacetime as well as in wartime there are many mothers in this country and many children who are in need of the kind of service that has been provided in this program.

"I believe it is a question for the Congress to decide as to whether or not the Federal Government will in the future make it possible for the mothers and children of this country to have the kind of care that they should have during the maternity period and during the period of childhood when proper growth, development, and health means so much to the health of future citizens of this country."64 Later she said: "Now, we have made mistakes in the past with respect to our estimates. Those mistakes were in the other direction. We estimated a figure that was far too low for the fiscal year 1944 and we had to come back to your committee for deficiency appropriations. In 1945 we underestimated the requirement of the program by a small amount and we had to come back for a smaller deficiency appropriation. I would hope that the committee, if it does decide to reduce the amount of the appropriation by $8,000,000, will make it possible for the Bureau to come back should it be shown as the year goes along that we have overestimated the reduction."

64Ibid., p. 593.
Representative Johnson: "... Mr. Chairman, may I add that most departments know their way back to this committee."65

The Subcommittee on Deficiency Appropriations was in high spirits, as well it might be, since the enormous government expenditures could now be reduced considerably. Representative Cannon, Missouri, Chairman, addressed Dr. Eliot: "I want to congratulate you on the splendid way in which you have administered this fund and the results you have secured. I do not think any money we have spent has been better invested than the money spent for this purpose."66

Mr. Ludlow, Indiana: "I want to express my unqualified admiration for the witness and the presentation she has made."

Mr. Johnson: "Mr. Chairman, I tried to express my unqualified approval of the program, in addition to my admiration for the witness and her statement.

"Let me say, seriously, that no witness has appeared before this Committee for a long time who has given us a more straightforward story or talked in a more intelligent manner about the program."67

On February 18, 1946 when the First Supplemental Surplus Rescission Bill for 1946 was passed (Public Law 301) the appropriation for the EMIC program was reduced by $8,113,600. However, the Children's Bureau overestimated the decreasing demand for services and on April 26, 1946 reported a need for $2,148,800 to supplement the appropriation for the fiscal year. This amount was

65 Ibid., p. 594.
66 Ibid.
67 Ibid., p. 595.
approved, sent to Congress on May 3, and passed on June 12, 1945 (Public Law 83).

On October 8, 1945, to prepare for the fiscal year beginning in July, 1946 the Children's Bureau believed it needed $18,548,400. A month later on the basis of new data this was reduced to $17,593,000. Congress received a recommendation for $17,593,000 of which $649,000 was to be expended for state administration. On July 26, 1946, Congress passed an appropriation bill of $16,664,000 of which $649,000 was to be allotted to the states for administrative expenses (Public Law 549,1946).

While this appropriation was under discussion the Children's Bureau submitted a request for $929,000 on April 29, 1946 to study the experience under the EMIC program. This sum was to be taken from the $17,593,000 requested by the Children's Bureau at that time. The proposed study excited much discussion in the hearings held on May 20, 1946.

Representatives Hare and Keefe asked if the study was an entirely new activity. Miss Lenroot said it was. Mr. Keefe stated:

"...I think it should be noted that there is no authorization at all for this appropriation. You concede that, do you not?" 68

Miss Lenroot answered: "Well, Mr. Chairman, as far as a study is concerned, I would think the act of 1912 would be sufficient authorization, directing us to investigate and report on all matters


*It will be recalled that Mr. Keefe at the beginning of the EMIC program was concerned with proper authorization. He did not think that the Social Security Act Title V was sufficient although he supported objectives of the program.
pertaining to children, child welfare and child life, and mentioning infant mortality specifically."69 This justification seemed to satisfy the subcommittee; the members then wished to hear about "the wisdom, possibility, and advisability" of the proposed study.

Miss Lenroot: "Mr. Chairman, the emergency maternity and infant care program has not been in operation for 3 years. This, as you know, is a unique program. Under that program, about one out of every seven births has been provided with care and all necessary arrangements.

"The Children's Bureau, from its earliest days, has been interested in infant mortality, which was mentioned specifically in the act creating the Bureau, and maternity mortality, and has made very important studies of maternal and infant mortality which have been widely used as a basis not only for public effort, but also for private effort.

"Many people have expressed a desire to have a study made of the experience under the emergency maternity and infant care program in order that we may know whether the mortality rates and the general results of care under that program compare favorably or unfavorably with the general experience in the total population. State health departments have wanted that information and have talked to us about their desire to know what their own experience showed. They have been unable to get conclusive information on the basis of State experience, because those mothers and babies move across State lines so much and you cannot decide what the infant mortality is, for example, for a series of births in the State of South Carolina... unless the Government follows those

69Ibid.
babies to wherever their mothers go and sees whether the baby lived or died."\(^7^0\)

Representatives Hare and Keefe doubted that a valid statistical study could be made, going into the details of research procedure to prove their point. They discussed comparability of data in different areas, experimental control groups, and so on, displaying a general knowledge of statistical research techniques. They thought the same result could be obtained on a much smaller scale. It was agreed that the program had been of great benefit to the young women who had received care. That did not need proof. "On the other hand," said Dr. Eliot, "I believe it exceedingly important from many points of view, to have a careful review and a careful study of the effect of this program, and of a series of factors that are involved in this program in order that we may analyze it effectively and know whether such a program as this is the way in which the States should proceed themselves, in their localities and on a State-wide basis, for the future."\(^7^1\)

Mr. Keefe: "That brings us right to the very hub of the situation -- and I intended to go into that at some time. There are people in this country who have discussed this matter with me, who believe that this program should be adopted as a permanent program of government. And I want to ask the blunt, plain question, whether or not this so-called statistical information that you are seeking to get as a result of this appropriation does not find its genesis in the thought that you will be able to show an experience which will justify the adoption of a national policy in this field, to continue this program on a national basis.

\(^7^0\)Ibid., p. 292.
\(^7^1\)Ibid., p. 294.
"Let us be perfectly fair about it. If that is the situation; I think the Congress is entitled to know it, and I say that as one, as you know, of the original sponsors of this program and one who had defended it and believes in it and has fought for appropriations for it.

"There is not any use of having any window dressing for this. I have had these people come into my office and discuss this matter with me, and they have indicated that they desire to have this investigation made for one specific purpose that outdistances everything else; namely, that it can be used as the foundation and the groundwork of a national health program. And they speak with great assurance, that the results will demonstrate so conclusively that this had been such a success, that it should be continued and adopted on a nation-wide basis, as part of a national policy."72

Mr. Hare: "That is just what I am afraid of, that this is going to be a lever to make it a national program. If you were to put me in charge, or put anyone else who is familiar with statistical methods in charge of this program, we could prove conclusively what they want to be proved, by the figures. There would be no doubt about it. It would be so convincing that we could not be excused from taking any position but that it should become a national program. And I don't know whether it should or not."73

Mr. Keefe repeated his question as to the motives behind the proposed study. Miss Lenroot answered: "In the first place I think the Bureau has stated the fact that it can make studies and desires to know the facts, whatever those facts may be and for whatever purpose they may be used as argument for or against a certain policy. That is what our infant mortality studies through

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72 Ibid.
73 Ibid.
the years have been - an effort to obtain the facts through the
best statistical procedures we could develop.

"When the emergency maternity and infant-care program was a
new program, I recall a conference where we had representatives of
certain organizations that were fearful of the possible extension
on a permanent basis of a program of this kind, who raised the
question as to what my attitude would be in the future. At that
time I said that I thought this experience, which was a wartime
program, should be evaluated; and the results might be used by
those who were against extension, or they might be used by those
who were for a permanent public program for maternity and infancy
care; but in either case I thought the facts would be valuable in
determining what should be done in the future. "I do not know
just what this will show. I have talked with some people who tell
me that the conditions of babies in some of these cases are below
the average of the general population, because the mothers are
young and have moved around and have lived under poor conditions,
sometimes have not had the right diet, and it may show in certain
cases excessive mortality among certain groups. But it seems to
me that just as we would not be afraid of having the facts show
whatever they may show, so the opponents of any permanent policy
for maternity and infant care also should not be afraid to have
the facts made known.

"In fact, we have been asked sometimes why we did not make a
study and have been asked whether we were afraid to have the facts
known, as to what was happening."74

Mr. Keefe: "Do you advocate a national program at this time?"

74 Ibid., p. 295-6.
Miss Lenroot: "... the Children's Bureau has been on record since 1917 as being in favor of a public program for the protection of maternity and infancy. That is what the Sheppard-Towner Act was in a small way. That is what title V, part 1 of the Social Security Act is. We believe that those programs should be expanded as soon as possible, so that there would be everywhere available, in every State, a service for the protection of the health of mothers at the time of childbirth, and the health of the children.

"We do not think this maternity and infant-care program, just as it is, should be the permanent program, because it had to be developed very hastily. The States need time to work out methods by which more adequate standards of care can be assured and by which all of the experience under this program and other programs can be assessed to determine the best way of organizing services. But I can frankly say that the Children's Bureau believes and has always advocated the extension of public care for maternity and infancy and childhood." 75

Mr. Keefe: "Along the same general lines as has been provided in this?"

Miss Lenroot: "No. There will be differences in the program and different methods of administration. Our administration of this program had to be very much more in the direction of Federal determination of procedures, because there was not time for the long, slow process of gradually developing with the States standards and policies. I would think of a long time, continuing program, being much more flexible, with much greater variations within the States and much less detailed prescription by the Federal Government than was the case with the emergency maternity and infant-care program."
Mr. Keefe: "But is it anticipated in the request for this money that the experience and the facts which you hope to develop may disclose a situation that would favorably dispose the Congress to adopt a permanent policy of Government in extending aid in some manner, in this field of maternity and child protection and obstetrical care?"  

Miss Lenroot: "Mr. Keefe, I do not know what the results will show, but I think that the people of the country are entitled to as much information as they can get concerning what care, such as that provided under the program, results in. I do not know whether it will be negative or positive in all respects. I think in many respects we could probably believe that it would be positive. But I know there are some people who think in some of these aspects there may be a negative finding. But I think the people of the United States are entitled to know after an investment of the amount of money that is represented in this program, what the program resulted in."  

Mr. Keefe was still not satisfied as to the motives behind the proposed study, and he repeated his question. Miss Lenroot: "As to your direct question, Mr. Keefe, the Children's Bureau from the time that it was created has had as its guiding motive the production of facts, but the fact-finding studies - and I have been with the Bureau since 1915, and a great part of that time not as head of the Bureau - I would say were not biased, or deflected according to any particular policy that the Bureau wished to advocate. The Bureau was created at a time when the public generally felt that if we could know the facts there would then be a basis for public

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\[76\] Ibid., p. 297.  
\[77\] Ibid.
action in determining what ought to be done. I still think that this is a valid purpose of Government and the first duty of the Children's Bureau."75 As was noted earlier, the request of $929,000 for a study of the EMIC program was not included in the final appropriation bill.

This testimony indicates that the members of the Committee on Appropriations of the House and Congress supported the EMIC program largely because it was designed to meet an emergency. As revealed in earlier hearings, there was fear of "socialized medicine" and the future extension of this type of program during peacetime. Another fact the testimony reveals is the fear of ulterior motives in social research which will bias the results in a desired direction, especially when the research is sponsored and conducted by a government agency in its own program.

From March, 1943 until the last appropriation bill passed on July 26, 1946 Congress had appropriated over $130,500,000 for the EMIC program. This program was channeled through a government agency which before this time was expending only around $11,000,000 under Title V of the Social Security Act.

During the short period of three years almost all members of Congress received communications from their constituents praising, condemning or simply requesting information about EMIC. They were from physicians, hospital administrators, servicemen and their wives. Communications were reported by the senators from 41 states and by the representatives from 48 states. The Children's Bureau and its regional offices received over 4,500 letters during one year alone, July, 1943 to July, 1944. It is clear that the EMIC program was close to the people; new policies and rules and regulations had an almost instant response.
CHAPTER IV

THE DEVELOPMENT OF RULES AND REGULATIONS

August, 1941 -- March, 1943:

Prior to May, 1942 the Children's Bureau had approved plans submitted by the states for maternity and infant care for the wives and infants of servicemen on an individual state basis. On May 1, 1942 the bureau drew up a formal set of policies which it sent to the state health departments to be used as a guide in drawing up programs for the fiscal year beginning in July, 1942. The bureau suggested that the plans and the request for funds for this supplemental service be submitted at the same time that the regular annual maternal and child health plan was submitted to the regional offices of the bureau.

The Children's Bureau, it will be recalled, had set aside 10 percent of the B fund of the maternal and child health appropriation for the fiscal year 1943, amounting to $198,000, for allotment to state departments of health wishing to finance this type of care. It was recommended that state health departments limit their budgets to the first quarter or the first and second quarters of the fiscal year. The bureau expressed the hope that additional resources would be made available to continue the program after the exhaustion of the B fund early in the fiscal year. To conserve the limited funds and to make sure they would be used where most needed the bureau asked that they be used for the cost of medical or hospital services not now readily available to the families eligible for these services.

1U.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. May 1, 1942.
The suggested policies, according to the Children's Bureau, were "prepared in an effort to assist the State agencies in drafting workable eligibility determinations and authorization procedures, establishing standards of medical and hospital care, and simplifying methods of payment for care." It was hoped that the plans of all the states would follow similar general policies in order to expedite the transfer of records from one state to another if the patient moved to another state after care had been authorized. This indicates the national scope of the problem, necessitating the formulation of many policies which would have nation-wide application. Services administered to beneficiaries who were on the move tended to minimize local and state characteristics and autonomy. Thus arose the issues of "centralization," "control from Washington," and so on.

The following principles were suggested as a guide in the development of the program for the wives and infants of men in military service:2

I. Beneficiaries.

A. All expectant mothers in the state, irrespective of legal residence, who state that the father of the expected child is in military service and not a commissioned officer.

B. Any child under one year of age whose father is in military service, but not a commissioned officer.

II. Application and authorization for care.

A suggested form or one similar to it (form 130) should be widely distributed to wives of men in military service by public health and welfare agencies, the American Red Cross, and military authorities.

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2 Ibid.

*See Appendix
Part 1 of this form should be filled out by the patient and part 2 by the attending physician, who should then send it to the state maternal and the child health director. The director should immediately notify the patient, the attending physician, the hospital (if hospital care is recommended by the attending physician), and the local health department or local public health nursing service.

Similar procedures should be established for authorization of medical and hospital care of infants eligible for these services.

III. Services.

A. A complete medical service for the wife during the prenatal period, including at least five prenatal examinations, delivery, puerperium (including care of newborn infant) and postpartum examinations. A minimum of ten days hospital care after delivery.

B. Home, office, and hospital care for the sick child under one year of age. Child-health supervision should be given in existing child-health conferences already operating under or in cooperation with divisions of maternal and child health in state and local health departments.

IV. Rates of Payment.

A. Physicians' services.

1. The suggested fee of $35 to obtain statewide to physicians for the complete maternity care described above. If prenatal care was provided in a prenatal clinic, or if less than five prenatal examinations were made by the attending physician, $25 might be paid for services during labor, the puerperium (including care of the newborn infant), and postpartum examinations.
2. For sick children it was suggested that the first medical visit might be paid for without prior authorization, but subsequent care should be authorized on a case basis, not on a fee per visit basis, the cost depending on the type and duration of the illness. The example given was: Pneumonia care authorization of $10 for home or hospital care during the first week of illness, with a minimum of three visits, or $5.00 each succeeding week of illness. Cost of pediatric care in excess of $20 per case should not be authorized without review of the case and recommendation by a pediatric consultant.

B. Hospital Services.

The actual per diem cost of operating the hospital, to embrace all costs of care while mother and newborn infant are in the hospital, including delivery room, laboratory services, drugs, and so forth, except the medical services of the attending physician. Hospital care for sick children should also be paid on a per diem cost basis.

V. Standards of Care.

A. Physicians.

1. Must be a graduate of a medical school approved by the Council on Medical Education of the American Medical Association and be licensed to practice in the state.

2. Prenatal care should be of a quality comparable to that recommended in the Children's Bureau publication, "Standards of Prenatal Care."

3. Obstetricians and pediatricians who are certified by the American specialty boards, or whose training
and experience meet the requirements of such boards, should be appointed consultants by the state health departments and, wherever possible, be made available for consultation with the general practitioners participating in the plan.

B. Hospitals.

1. Hospitals must either have been approved by the American College of Surgeons or inspected and approved by the state health agency as meeting the standards, established by the state health agency, for obstetric and pediatric service. There should be a minimum of ten days hospital care after delivery.

VI. Other.

A. The patients are to have free choice of physicians and hospitals participating in the program; however, where the case load is concentrated in certain areas the employment of full-time or part-time qualified obstetricians and pediatricians was suggested. It was felt that this arrangement would assure high standards of medical care, and payment on a salary basis would eliminate the difficulties of fee schedules.

B. The fees and rates paid to physicians and hospitals by the state health departments are to cover the entire cost of the services. The patient is not to pay anything.

On January 1, 1943 the rules and regulations were modified and expanded superseding the first rules and regulations issued on May 1, 1942. Hospital payment was limited to the cost of ward care.
It was suggested that all patients should be referred immediately to local health departments for nursing services in the home, including bedside-nursing care if necessary, before, during, and after delivery. Care could be purchased from a local visiting-nurse agency when it could not be made available by the public health nursing service of the local health department. Special nursing care in the hospital might be authorized upon the request of the attending physician for maternity patients or infants who are seriously ill. Rates of payment to nurses were not mentioned.

For patients needing assistance in dealing with personal problems referrals should be made to the appropriate state or local welfare agency.

The inclusive rate for complete maternity service should also include the care of complications and operations. In other words the physician would receive the same fee for complicated cases as for uncomplicated ones. It was felt that the established fee was an average for all types of cases which the physician might encounter over a period of time.

The definition of per diem hospital cost was clarified on July 23, 1942 and incorporated in the current memorandum. The policies adopted at this time were to be effective a year later so as to enable the hospitals to acquire the data needed. The policies included:

1. Hospital care shall be at a rate not to exceed the ward cost per patient day calculated by each hospital according to the formula presented by the Children's Bureau.

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\(^4\) U.S. Children's Bureau, Memorandum from the Chief to the State Health Agencies a Purchase of Hospital Care under Crippled Children's or Maternal and Child Health Programs, July 23, 1942.
2. Each hospital participating in the program shall prepare for the state health department, before May 1 each year, a statement of its operating expenses for its most recent accounting year.

3. Payments per patient day for ward care, after 14 days' hospitalization of any individual, shall not exceed 75 percent of the calculated ward cost per patient day.

4. For the purpose of computing the cost of ward care it was estimated that the cost of such care approximated 85 percent of the cost per patient day for all types of in-patient services.

It is apparent that a few of the administrative problems were beginning to appear even though the number of cases handled each month was still only in the hundreds. The program was becoming large enough so that exceptional cases were creating a problem in the determination of fees. The flat fee for maternity cases was not designed to cover exceptional cases needing unusually skillful and long care. The same fee was to cover both uncomplicated and complicated cases.

The determination of hospital costs was also becoming a larger problem as more EMIC patients were hospitalized. Since a government agency paid nonprofit hospitals only the actual cost per patient day of operating the hospitals, it became the hospitals' responsibility to make an accurate determination of what constituted cost. A great many hospitals were not prepared to do this because they had not established scientific accounting systems. Hence the state health departments were notified by the Children's Bureau on February 1, 1943 that hospital administrators should be advised that regional auditors of the bureau would verify the hospital statements by actual
audit of hospital expenditures each year in a spot check of a few hospitals in each state. However, this was never put in effect. Hospitals which were paid less than $100 a year by the state health department did not need to submit an operating statement.

Again on March 15, 1943 a memorandum on the purchase of hospital care was issued superseding the two previous memoranda. A more explicit statement of what should be included in the ward cost of a hospital was prepared; the other memoranda had left too many unknowns. Hospitals receiving payments for care totalling less than $500 a year were given the choice of submitting a statement of their operating costs or accepting the inclusive per diem rate established by the state department of health.

March, 1943 -- December, 1943:

On March 18, 1943 the first EMIC appropriation act was passed by Congress. The Children's Bureau drew up another set of policies, MCH Information Circular No. 13, issued on March 29, 1943 superseding all other memoranda in order to comply with the act and the intent of Congress.

The text of the act read in part, "...to provide, in addition to similar services otherwise available, medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men in the armed forces of the United States of the fourth, fifth, sixth, or seventh grades, under allotments by the Secretary of Labor and plans developed and administered by State health agencies and .

5U.S. Children's Bureau, Memorandum from the Chief to the State Health Agencies on Purchase of Hospital Care under the Crippled Children and Maternal Child Health Programs, February 1, 1943.

6U.S. Children's Bureau, Memorandum from the Chief to the State Health Officers on Purchase of Hospital Care under the Crippled Children and Maternal and Child Health Programs, March 15, 1943.
approved by the Chief of the Children's Bureau.\textsuperscript{7} The bureau was empowered to administer the programs in accordance with the procedures, policies, and regulations relating to the maternal and child-health program, Title V, part 1, of the Social Security Act.

In the MCH Information Circular No. 13 the Children's Bureau presented in detail the information required of the state health departments before their plans would be approved. The states were required to indicate eligibility, methods of application for care, methods and policies of authorizations for payment of services, referrals for medical services, nursing services, nursing services, and social services, rates of payments for medical services and hospital care, standards to be followed for all services, and all pertinent statistical and financial data. The bureau established requirements on all these items with which the states had to comply in order to get their plans approved. Since this was an emergency program and completely Federally financed, and since the services provided were to be made available to eligible wives and infants even though they moved from state to state, the bureau felt and assumed a great deal of responsibility in detailed policy formulation.

Three items in the act itself conditioned the seeming rigidity of the policies formulated by the bureau. These items contained the apparent intent of Congress and had a great bearing on the nature of the administrative process down to the local level. The services to be provided were clearly stated; the fact that the benefits were to be in the form of service and not cash was unmistakably implied; and the exclusion of a means test was easily interpreted. Thus, immediately the provision of medical, nursing,

\textsuperscript{7}U.S. Children's Bureau, MCH Information Circular No. 13, Revised, March 29, 1942. Instructions to State Health Agencies with Regard to Plans and Financial Reports Related to Emergency Appropriations for Maternity and Infant Care. 12p.
and hospital care for maternity patients and infants was made mandatory. The personnel and facilities had to be marshalled and these were to be utilized for the benefit of the group designated in the law, regardless of income. From the conditions set by the law flowed many policies to implement and apply it. Only by tracing the administrative process from the law to the persons who benefit from it can the process be understood and evaluated.

The chief changes in the policies after the first EMIC appropriation act will be described in some detail. Whereas, using B funds, care had been given to all wives and infants of men in service below commissioned officers, the present law designated the pay grades of the fourth, fifth, sixth and seventh grades in the Army, Navy, Marine Corps, or Coast Guard as the eligible ones. This excluded the families of commissioned officers, of master, major, first, technical, staff, and platoon sergeants, and of chief, first, and second-class petty officers. On the application form for care the wife was to indicate the husband's serial number and rank, verified by the attending physician from the applicant's allowance card or a letter from the husband.

Subjects covered by the policies are shown in the following brief résumé:

1. Application for authorization for hospital care in case of emergency should be submitted by the hospital or attending physician within 24 hours of admission to a hospital. These applications may be retroactive to cover the emergency period while authorization was pending.

2. Initial authorization for hospital maternity care should not be for more than 14 days, and a minimum stay of 10 days post-partum should be arranged if at all feasible. Previous rules and regulations had not designated a limit on the number of days.
3. The attending physician and the hospital are to understand that they may accept no payments from the patient or family for services rendered. Payment from the state department of health is to constitute payment in full.

4. Hospital out-patient departments or health department clinics that have arrangements for complete maternity care should be utilized as well as the services of physicians in their own offices.

5. Complete maternity care was further defined to include routine blood tests for syphilis, hemoglobin determinations, and urinalyses.

6. Differential rates of payment to general practitioners and specialists were suggested. Specialists may receive approximately one-fourth to one-third higher fees than general practitioners. To be designated a specialist and to qualify for a higher rate the obstetricians had to be certified by the American Board of Obstetrics and Gynecology. Assistant consultants had to have one or more years of graduate training in obstetrics in an approved residency.

7. As the need arose, it was suggested that the fee schedules for nonobstetric surgery and specialized consultants services should be considered by the state health agency in conference with a technical advisory committee selected and appointed by the state health agency. These fee schedules should be submitted to the Children's Bureau for approval.

8. Rates of payment to physicians for the care of sick infants was made more explicit. It was recommended that such care be financed on a case basis if more than three visits were required; for example, $10 for home and hospital medical care during the first week of illness and $5.00 for home, office, and hospital medical
care for succeeding weeks, with a minimum of three visits per week and for periods of not longer than three weeks. Renewal of authorization for more prolonged medical care should be given only after review of the case by the maternal and child-health director or a pediatric consultant appointed by the state health agency.

Higher rates of payment were suggested for medical services rendered by pediatricians certified by the American Board of Pediatrics or for assistant consultants who have had one or more years of graduate training in pediatrics in an approved residency. These rates could be from one-fourth to one-third higher than those paid physicians who have not had the additional graduate training and experience.

As the need arose, fee schedules for minor or major surgery for infants, specialized consultant services, and rates of payment for care of sick infants for periods of longer than three weeks should be considered by the state health agency in conference with a technical advisory committee selected and appointed by the agency. These fee schedules should be submitted to the Children's Bureau for approval.

9. When review of the maternity or pediatric records submitted shows that the standards of care recommended have not been provided, the state health agency should not authorize further care by such physicians.

10. Provision may be made for reimbursing physicians for the cost of long-distance telephone calls for consultation for patients when bedside consultation is not feasible.

11. Further refinement in the determination of per diem hospital cost for ward care was required. Since the services of intern and resident staff are included in the hospital ward cost
per patient day, the intern and resident staff may not receive extra remuneration from the state health department. Also, payments may not be made to attending physicians for services customarily provided to ward patients in hospital without reimbursement.

12. The services usually provided by hospitals were expanded to include the cost of blood for transfusions and similar exceptional services. These were to be paid for at the customary ward rate and were not part of the per diem ward cost.

13. Some changes were made in the original qualifications for physicians who could participate in the program in order to provide for exceptions and assure as many eligible physicians as possible. Originally the only physicians eligible to participate were those who were graduates of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association. The new ruling provided that individual exceptions may be made when a person with the degree of Doctor of Medicine who is a graduate of a medical school not approved by the American Medical Association has completed postgraduate training in obstetrics and/or pediatrics which, in the opinion of the state health officer and his technical advisory committee, makes him competent to participate.

14. Regarding hospital standards it was recommended that those employing intern and resident staff and meeting the standards for institutions approved for internships or residencies should be selected. Hospitals having an obstetrician and a pediatrician, certified or otherwise fully qualified, on the attending staff should be preferred over those which do not.

Thus, as the program expanded and administrative problems increased the need for revisions and expansions of the rules and regulations became apparent. The emergency nature of the program...
and the limited experience with medical administration prevented
the formulation of policies and rules and regulations which would
be adequate for a rapidly expanding program without frequent and
sometimes confusing revisions.

The policies were called information circulars and the frequent
interpretations of the information circulars were usually called
memoranda. Between the issuance of the MCH Information Circular
No. 13 on March 29, 1943 and EMIC Information Circular No. 1 in
December, 1943 superseding all previous policies and memoranda,
the Children's Bureau released 10 memoranda to the state health
departments interpreting the policies set forth in March, 1943.
Four of these were occasioned by the results of hearings before
the Committee Appropriations of the House of Representatives.

On April 10, 1943 the Children's Bureau as a result of a con-
ference with its advisory committee of obstetricians and pediatri-
cians issued a memorandum amending the policy in regard to phy-
sicians' fees for sick infants. For initial home visits the fee
should be $1.00 a visit and for initial office and hospital visits
$2.00. Subsequent visits should be $2.00 and $1.00, respectively.
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.

The ruling relating to the non-payment of physicians for
medical care in hospital wards if the physicians customarily con-
tributed their services in the wards was changed on April 14, 1943
when instances were found where patients under the program were not

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8 U.S. Children's Bureau. Memorandum to the State Health Agencies
on MCH Information Circular No. 13, April 10, 1943.

Provided by the Maternal and Child Health Library, Georgetown University
in the same category as patients previously accepted for ward services. The new rule permitted the payment of the attending physicians for services to private patients occupying ward or other accommodations. It was also explained why the provision for the differential fee for specialists was omitted. This was done on the recommendation of the obstetricians and the pediatricians of the advisory committee to the bureau, the recommendation stating that at the request of the states, not at the suggestion of the bureau, differential fees might be included and approved.

In answer to inquiries from the states asking if funds for the EMIC program may be paid directly to the wives of enlisted men, the Children's Bureau on July 6, 1943 issued a memorandum stating explicitly that this could not be done. This was also the opinion of the Solicitor of Labor in the Department of Labor, the legal consultant for the department, in a discussion held on December 8 and 9, 1943. The EMIC plan of the state department of health of North Dakota was refused approval because of the inclusion of cash grants to the patients. The Solicitor ruled against the North Dakota proposal on December 16, 1943.

When the appropriation bill for 1944 was passed on July 12, 1943, the state health departments received instructions two days later that the Children's Bureau was prohibited by a proviso added to the appropriation act for the fiscal year 1944 from establishing

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9U.S. Children's Bureau, Memorandum from Dr. Daily to Regional Medical Consultants on the Memorandum of April 10, 1943 to State Health Agencies Relating to Maternal and Child Health Information Circular No. 13, April 14, 1943.

10U.S. Children's Bureau, Memorandum from Dr. Daily to Regional Medical Consultants on the Memorandum of April 10, 1943 to State Health Agencies Relating to Maternal and Child Health Information Circular No. 13, April 14, 1943.

11U.S. Children's Bureau, Memorandum to State Health Officers and Maternal and Child Health Directors, July 6, 1943.

Provided by the Maternal and Child Health Library, Georgetown University
standards which would discriminate between persons licensed under state law to practice obstetrics. The Attorney General of the United States advised the Secretary of Labor and the Children's Bureau on July 14 that this was the meaning and intent of the law. On July 28 another memorandum was sent to the state health agencies interpreting the instructions sent them two weeks previously regarding discrimination between practitioners. Many states had not understood the new ruling fully. The Wisconsin State Department of Health insisted on discriminating between persons licensed to practice obstetrics in the program and it had the support of the Attorney General of that state. The Children's Bureau could not very well force the state health department to open the program to all licensed to practice obstetrics in the state, because, according to the Federal interpretation that would be interfering with a purely local administrative matter.

To comply with the language of the appropriation act passed on July 12 for the fiscal year 1944 the Children's Bureau notified the states that although services should be limited to wives and infants of enlisted men in the fourth, fifth, sixth, and seventh pay grades certain hardship cases could be included in the first three pay grades. 12

After considering many recommendations made by state health departments and hospital administrators the Children's Bureau revised some of the policies relating to the determination of per diem hospital costs on September 1, 1943. When hospitals did not or could not submit an acceptable statement of operating expenses, an inclusive per diem ward rate not to exceed $1.25 a day was to be paid during the fiscal year.

12 U.S. Children's Bureau. Memorandum from the Chief to the State Health Agencies, July 20, 1943.
Many inquiries had been received by the Children's Bureau as to whether a patient under the EMIC program might pay a portion of the care rendered. The patient might wish to pay the physician's bill or the hospital bill herself. The Children's Bureau recommended that the patient may be permitted to pay a portion of the bill provided such payment is made to the state health department and credited to the EMIC account.\textsuperscript{13}

In September supplemental funds were provided by Congress and the law governing the EMIC program was amended striking out the inclusion of the first three pay grades even if they were hardship cases. The states were notified to this effect on September 29, but they had to be renotified on November 17.

**December, 1943 -- March, 1945:**

In December 1943 all the information circulars and memoranda on the EMIC program were consolidated and expanded to comprise EMIC Information Circular No. 1.\textsuperscript{14}

The following changes were made:

1. The effective date of authorization from which the state health department assumes responsibility for payment for services shall be the date during pregnancy when the wife first requested care from physician, clinic, or hospital, provided the application, signed by physician, is received by the state or local health agency within six weeks after the date when the wife first requested care under the program.\textsuperscript{15} The effective date of authorization for medical

\textsuperscript{13} U.S. Children's Bureau. Memorandum from the Chief to the State Health Agencies. September 7, 1943.

\textsuperscript{14} U.S. Children's Bureau, EMIC Information Circular No. 1. December, 1943. Administrative Policies; Emergency Maternity and Infant Care Program. 21 p.

\textsuperscript{15} Ibid., p. 5.
care of a sick infant shall be the date when the physician, clinic, or hospital agreed to give care provided it is not more than ten days prior to the date when the application was received in the state or local health agency. 16

2. Ward care should be provided but the hospitals must provide whatever accommodations are indicated by the patient's medical condition at the per diem ward rate paid by the state health department. Authorizations may be made for a maximum of 1½ days with extension of care when necessary for two-week periods after review by the state or local health agency. The same conditions apply to sick infants.

3. The number of prenatal visits required before the physician may receive the full fee established for complete maternity care was increased from five to seven. The rate of payment could be set by the state health department, but not in excess of $50.

4. The problem of paying for services rendered during pregnancy for conditions which were not due to pregnancy had arisen. Supported by the legal opinion of the Solicitor of the Department of Labor the Children's Bureau ruled that additional payments may be paid by the state health department for medical care and major surgery for "intercurrent nonobstetric conditions" in the home and hospital. Treatment in the office was to be considered as part of the complete maternity service with no extra payment. Major non-obstetric intercurrent surgical operations may be performed by physicians who qualify as consultants in a surgical specialty at a rate not to exceed $50 for preoperative, operative, and postoperative care. Additional payments may also be made for medical care of other intercurrent nonobstetric conditions in the home or

16 Ibid., p. 6.
hospital for a period of three weeks which do not require major surgery. The maximum rate of payment was to be $12 for the first week of illness for four visits. If fewer than four visits are made the rate of payment should be reduced proportionately. For succeeding weeks of illness the rate of payment should not exceed $6.00 a week.17

5. When only prenatal care is provided by the attending physician the rate of payment for seven visits should not exceed $15. If less than seven visits are made the rate of payment should be reduced proportionately. If the pregnancy terminates in spontaneous abortion not requiring an operation the fee should not exceed $15, plus proportionate payment for any prenatal examinations made. The rate of payment for therapeutic abortions or spontaneous abortions requiring an operation should be the rate established by the state health department for complete maternity care, and not in excess of $50.18

6. The rates of payment for medical care, including minor surgery, for infants under one year of age should not exceed $12 for the first week of illness, and should include at least five visits. For succeeding weeks $6.00 a week should be paid for at least three visits a week. The rate for complete major surgical care should not exceed $50.19

7. Immunizations may be provided infants in physicians' offices or at child-health conferences or immunization clinics not conducted by state or local health departments. The rates of payment should not exceed $6.00 for immunization for smallpox, diphtheria, and

17 Ibid., p. 7-8.
18 Ibid., p. 8.
19 Ibid., p. 10-11.
whopping cough plus the cost of biologicals if not furnished by
the state or local health departments. These immunizations will
usually require during the first year of life one procedure for
smallpox, two or three for diphtheria, and three for whooping
cough.\textsuperscript{20}

8. Bedside nursing in the hospital or home when requested by
the attending physician should be authorized for a period not to
exceed four days, with review by the state or local health agency
before authorizing extension of care. The rate of payment should
be the prevailing local hourly or per diem rates not to exceed the
maximum rate established by the state health agency.\textsuperscript{21}

Bedside nursing in the home may be authorized for care of mother
and infant while the mother is receiving bed care during the puer-
perium. The number of visits should not exceed six, with review
by the state health department before authorizing extension of care.
Home visits for care of a sick mother or infant may be authorized
but not to exceed 14 visits. Home nursing visits may be authorized
for the period of labor and delivery. The rates of payment for
these services should be at the prevailing local rates but not to
exceed the maximum established by the state health department.\textsuperscript{22}

The policies covering the mechanics of administration remained
substantially the same. It is seen that there were attempts to
separate physicians' services, nurses' services, and the medical
needs of mothers and infants into definable units. Thus rates of
payments, quality of care, and the need for care could more easily
be placed within an administrative framework.

\textsuperscript{20}Ibid., p. 12-13.
\textsuperscript{21}Ibid., p. 13.
\textsuperscript{22}Ibid.
For a short time all the policies for the program could be found in a single source; then information circulars and memoranda began to flow again. From December, 1943 to October, 1944 around 30 revisions in the policies contained in EMIC Information Circular No. 1 were issued.

On January 15, 1944 the Children's Bureau released a memorandum to the states regarding the review of hospital accounts. "It appears that some State agencies have gained the impression that they should take no responsibility with regard to review of statements of operating costs received from hospitals for the purpose of detecting possible accounting errors or departures from instructions for preparing the statement." The state health departments were told that they have the responsibility. "However, it is recognized that this was not made clear in the instructions issued to the State agencies."

Many of the patients receiving care in the EMIC program carried hospital insurance covering maternity care. The Children's Bureau ruled that the patients might use their hospital insurance if they wished, but they were advised to use the EMIC benefits exclusively and save their hospital benefits -- usually limited to a given number of days per year -- for other purposes. If the hospital insurance was on a cash indemnity basis, the patients may receive that money as well as the service benefits from the EMIC program.

In March, 1944 the Children's Bureau felt it necessary to write a letter signed by Miss Lenroot to all the state health officers.

23 U.S. Children's Bureau. Memorandum from the Division of Health Services to the State Agencies Administering MCH, EMIC, and CC Programs. January 15, 1944.
24 U.S. Children's Bureau. Memorandum from Dr. Deitrick to the Regional Medical Consultants on Hospital Insurance Maternity Benefits. February 26, 1944.
dealing with exceptions and cases not specifically mentioned in the policies formulated by the bureau. Apparently the state health departments had been hewing so closely to the letter of the rules and regulations that some potentially eligible patients were not receiving care under the program because of technicalities. The letter read in part: "...the Children's Bureau...recognizes the fact that State plans for a program of this magnitude cannot describe the method of handling all situations involving occasional deviation from the established policies and that appropriate exceptions must necessarily be made in view of the circumstances in individual applications for care. These decisions must be made by the State health agencies in the light of the intent of the program which is primarily to see that care is provided for eligible individuals and to relieve enlisted men and their families of uncertainty or anxiety as to how the cost of care will be met. When in your judgment an eligible wife or infant of an enlisted man would be denied care to which they are entitled under the program, and hardship and injustice result, you must certainly act in the best interest of the patient concerned..."25

During the course of the year important revisions were made in the length of time care could be authorized and in the rates of payment. The limitations on the length of medical and hospital authorizations in EMIC Information Circular No. 1 were found unsuitable for certain patients, such as premature infants requiring long-term care. This was amended so that medical and hospital care might be authorized for a period not to exceed two months. If additional care were required, extension for a maximum of one month

25 U.S. Children's Bureau. Letter from Lenroot to State Health Officers, March 11, 1944.
might be authorized after review of the case by the state or local health department. 26

A policy established in April, 1914 provided that rates for medical care for sick infants, including minor surgery, should not exceed $2.00 for the first three weeks, and for succeeding weeks of illness not over $6.00 per week. The maximum rate of payment for a home visit should not exceed $3.00 and an office or hospital visit not over $2.00. 27 In the same amendment these rates were also recommended for medical care for intercurrent nonobstetrical conditions.

An amendment was added later to equalize the periods authorized for both hospital and medical for sick infants. Hospital care for sick infants might be authorized for 21 days, with extension of care authorized when necessary for three-week periods after review of the case by the state or local health department. 28 This ruling seems to overlap the other ruling dealing with long-term care for certain types of cases.

Another amendment gave the states greater latitude in adjusting payments to physicians on an individual case basis for extraordinarily severe cases that require an exceptional amount of care within the period of time covered by a single authorization. 29 The flat-fee basis for all types of cases was not considered as equitable payment for such exceptional cases.

26 U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 1, March, 1914.
27 U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 3, April, 1914.
28 U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 7, August, 1914.
29 U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 9, August, 1914.
A new policy in September, 1944 extended the services for infants by permitting office care during their first year of life instead of a new authorization every three weeks as had been the previous requirement. This would include the office care of infants when sick or for immunization, or for general advice on care. The rate of payment for such care should not exceed $16 a year with appropriate reductions on an equitable basis when the minimum services required by the state health department have not been provided. For health supervision, including immunization, provided at a child-health conference, the rate for office medical care should not exceed $10 a year.\textsuperscript{30} In another amendment on the same date it was stipulated that health supervision may be purchased through EMIC funds for infants from voluntary health agencies conducting child-health conferences. Maximum payment for this service during the child's first year of life should not exceed $15. The same service in a physician's office should not exceed $24 a year.\textsuperscript{31}

Differential rates of payment between specialists and general practitioners were not mentioned in EMIC Information Circular No. 1 although the states could establish such rates if they wished to do so. In August, 1944 the Children's Bureau issued an amendment stating that rates of payment to specialists may be established at the option of the state health department but not to exceed by more than 50 percent the rates paid general practitioners.\textsuperscript{32}

\textsuperscript{30}U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 10. September 15, 1944.
\textsuperscript{31}U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 10. September, 1944.
\textsuperscript{32}U.S. Children's Bureau. EMIC Information Circular No. 1 Amendment No. 8. August, 1944.
In the same amendment the Children's Bureau stated that if differential rates of payment for specialists in obstetrics are established, the state health department should determine the qualifications for specialists. In differentiating between specialists in obstetrics and general practitioners in the state health department should show that the group identified as specialists includes only physicians who have had superior training and customarily receive higher fees than general practitioners. Recommendations were also made for the determination of specialists other than those in obstetrics. These specialists were defined as physicians who are graduates of medical schools approved by the Council on Medical Education and Hospitals of the American Medical Association and who have been certified by their respective American specialty boards or have the training and experience for admission to the examinations of such boards.

March, 1945 -- July, 1946:

In March, 1945, all the amendments and memoranda relating to EMCIC Information Circular No. 1 of December, 1943 were consolidated and a few new provisions were added. The major change in administration was the provision that when an expectant mother applies for maternity care the same application will automatically authorize care for the future child for one year after birth. Thus, the mother is saved the trouble of applying twice. Other changes included the following:

1. In the earlier information circular seven prenatal visits were considered the minimum number of visits for complete maternity care. In the new circular this number was reduced to five.

2. Circumcision of an infant over two weeks of age on medical indication might be authorized at a rate of payment not to exceed $5.00 including aftercare, rather than payment as a visit basis, at the option of the state agency. Circumcision performed within two weeks after birth is considered part of the complete maternity service with no extra remuneration.

3. Additional payment for time in travel and for cost of travel for physicians may be authorized for attending seriously ill patients or for home or hospital deliveries and aftercare outside of city limits of physicians' residences. The rates are not to exceed 25 cents per mile each way traveled outside of the city limits, with a maximum payment of $25 to a physician for travel for any one case.

4. Payment for cost of travel in addition to payment for services of a graduate nurse not employed by a public or voluntary health agency to the home of a patient may be allowed at the cost of transportation outside of the city limits on a public carrier or at the usual rate for mileage established for state employees.

5. At the option of the state health department drugs prescribed by the attending physician for patients not hospitalized may be purchased under the EMIC program. The policies and procedures are to be established by the state health department.

From March, 1945 until July, 1946 the Information Circular No. 1 (revised) was amended 12 times. There was a tendency to give the states more administrative discretion. Several state health department officials had requested that an interpretive policy statement be issued to clarify the recommendations of the bureau regarding the use by recipients of the EMIC program of voluntary prepayment medical and hospital plan benefits. The
bureau ruled that "Prepaid medical and/or hospital service benefits for maternity or infant care are considered as payments made in behalf of the patient; however, cash-indemnity insurance benefits paid to the insured are not considered as payments made in behalf of the patient." It will be recalled that any payments to attending physicians or to hospitals in behalf of the patient made her ineligible for the cost of care. The bureau stated that the policy "is in conformity with the basic philosophy of the emergency maternity and infant-care program, that benefits are to be made available to all eligible wives and infants on the same basis and without regard to their economic resources. Use of prepaid service benefits for maternity and infant care would greatly reduce benefits available to servicemen's dependents for other illnesses, because many prepaid medical and/or hospital benefit contracts limit the care for which payment may be made in a given period of time."

On the recommendation of the Maternal and Child Health Committee of the Association of State and Territorial Health Officers the ruling regarding the maximum payment of $25 to a physician for travel on any one case was eliminated.

Several state health departments had indicated that under the present policies difficulties were occasionally encountered in hospitals which have a limited resident staff and require the services of a physician on the visiting staff to assist the surgeon. The Children's Bureau revised its policy so that payment to a physician assisting the surgeon in a surgical operation in hospitals

without available resident staff might be authorized at a rate not to exceed $10 per operation.  

The Association of State and Territorial Health Officers recommended to the Children's Bureau that as an alternative to the procedure for adjusting the rate of payment to physicians for maternity care to cover only the services actually rendered, a state health department may pay physicians the maximum allowed for each maternity patient provided they can show proof that for three consecutive months complete maternity care has been rendered to 80 percent or more of the maternity cases in which patients are delivered. The recommendation was accepted and the Information Circular was so amended. This was intended to reduce the amount of administrative detail in the states.

After the surrender of Germany the discharge rate from the armed forces increased considerably so that applications for maternity care by the wives of service-men were made after their husbands had been discharged. This brought up the question of whether the applicants in such a circumstance were eligible for care. In accordance with the recommendations made by the Committee on Appropriations of the House in its report (No. 551) of May 14, 1945 the Children's Bureau ruled that if the wife became pregnant while the husband was in service even though he might have been discharged before application was made for care, such applicant would be eligible.

In July, 1946 a series of amendments were issued involving revisions in the policies which the state health departments could

apply or not as they saw fit. These changes were part of an attempt to allow greater discretion in the formulation of administrative policies by the states.

The experience of the state health departments had shown that the majority of sick infant cases require relatively prolonged care, necessitating a large number of supplemental authorizations under the three-week period of authorization. The following optional amendments were issued: (1) The initial authorization for care of a sick infant by a physician might be for a period up to four weeks, (2) The rate of payment for this care should not exceed $3.00 for the first four weeks of illness, and for succeeding weeks $6.00 per week. The maximum rate of payment for a home visit should not exceed $3.00 and for an office or hospital visit $2.00.³³

Although the definition of "complete maternity care" included care of the infant during the first two weeks of life, it was considered desirable to make some provision for additional payment to the physician in cases where the newborn child was ill and required special care continuing beyond the first two weeks of life. The Children's Bureau ruled in an optional amendment that if an infant becomes ill during the first two weeks of life and the illness extends beyond that time care of the infant might be authorized retroactively beginning with the first visit for the illness.⁴⁰

Another amendment permitted the state health departments, if they wished, to use state funds to supplement federal funds for the purpose of increasing the maximum rates for professional services.

This would theoretically permit greater state variables in professional fees.41

Many state health departments had experienced difficulties in applying the policies regarding the qualifications for physicians performing surgery. This was especially true in sparsely settled and predominantly rural states. In these areas general practitioners had been accustomed to perform whatever surgery was needed. The Children's Bureau believed that wherever qualified surgeons were available they should be used. An optional amendment was issued to encourage consultation on the part of general practitioners before they performed a surgical operation. The amendment stipulated that additional payments might be authorized to the attending physicians for major or intermediate surgical operations performed by them during pregnancy and six weeks postpartum for conditions not attributable to pregnancy provided that a consultant approved by the state health department had examined the patient before the operation and there was agreement on the diagnosis and treatment planned. The same rule might apply to major or intermediate surgical operations on infants. In either case minor surgery might be authorized at a rate of payment not to exceed $5.00 inclusive of aftercare, rather than payment on a visit basis.42

The original information circular stated that if pregnancy terminates in spontaneous abortion not requiring an operation the rate of payment to the physician should not exceed $15, plus proportionate payment for prenatal examinations made. An optional amendment suggested was that if it is necessary for the patient

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41 U.S. Children's Bureau. EMIC Information Circular No. 1 (Revised March, 1945) Amendment No. 8, July, 1946.
to be hospitalized for complications such as hemorrhage or infection, the rate of payment might be increased depending on the amount of care given but not to exceed the amount established by the state health department for complete maternity care. 143

The last amendment issued related to additional payment to anesthetists for prolonged services. If the patient is hospitalized in a hospital that does not employ an anesthetist or if the patient is delivered at home, the services of an anesthetist may be authorized at a rate not to exceed $10. However, in exceptional cases, when anesthesia is required for two hours or longer, additional payments to anesthetists may be authorized at rates established by the state health department and submitted to the Children's Bureau. 144

Opinions of the Solicitor of the Department of Labor:

In the administration of the EMIC program it is evident that the Children's Bureau never took an action which might lead to conflicting legal interpretations without first presenting the problem to the Solicitor of the Department of Labor for guidance.

Some of the major problems of legal interpretation and administrative prerogatives submitted to the Solicitor follow. On February 1, 1944 the Children's Bureau requested the Solicitor to review the legislative history of the EMIC program for the purpose of expressing an opinion as to whether the policies adopted by the bureau concerning supplementary fees from the patients to the physicians and hospitals were in conformity with the intent of Congress. The Solicitor concluded: "After reviewing the legislative history relating to the EMIC program, I adhere to the conclusion expressed

143 U.S. Children's Bureau, EMIC Information Circular No. 1 (Revised March, 1945) Amendment No. 11, July, 1946.
144 U.S. Children's Bureau, EMIC Information Circular No. 1 (Revised March, 1945) Amendment No. 12, July, 1946.
in my memorandum of December 9, 1943 that the Chief of the Children's Bureau, as a condition to the approval of State plans, may require that physicians and hospitals participating therein be compensated for services and care by payments made by State health agencies exclusively."

Early in 1944 the Michigan State Medical Society requested that the Michigan EMIC plan be amended so that the state health department could turn the EMIC funds over to the voluntary medical prepayment plan. This organization would then pay the physicians for services rendered in the EMIC program authorized by the state health department. The Michigan State Medical Society was attempting to free the physicians from direct contact with a government agency.

During 1944 the bureau submitted this problem to the Solicitor three times. Each time the Solicitor saw no justification for the procedure, and the bureau withheld its approval. In substance the Solicitor said that under the Social Security Act, Title V, part I, the Children's Bureau was under duty to provide for methods of administration necessary for the proper and efficient operations of its programs, and he thought the inclusion of the Michigan Medical Service would make the administration of the EMIC program cumbersome and slow. "The Service is a mere volunteer and not answerable legally for the extent to which it performs its undertakings nor for its efficiency." Again on April 19, 1944 the Solicitor stated: "The consequence of putting into effect the proposal of the State of Michigan is to give recognition, publicity and the

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45 Memorandum from the Solicitor of the Department of Labor to the Children's Bureau Concerning Payment of Supplementary Fees by Wives of Servicemen to Physicians and Hospitals. February 26, 1944.

46 Memorandum from the Solicitor of the Department of Labor to Miss Lenroot on the Proposed Amendment to the Michigan EMIC Plan. January 25, 1944.
color of official status to a private and non-governmental agency. These are not among the objectives of the legislation. 47

When the question of differential rates of payment to general practitioners and specialists in obstetrics came up the Children's Bureau asked the Solicitor if differential rates were legal since the bureau was not permitted to designate who may practice obstetrics in the program. The Solicitor stated: "The legislative history of the obstetrical provision is sufficiently clear to justify the interpretation that it was intended to prohibit the Children's Bureau from discriminating between those who may be licensed to practice obstetrics in a State. It does not apply to discrimination in the payment of fees to obstetricians and general practitioners engaged in obstetrics. Under this view it would appear not to be in violation of the proviso for the Children's Bureau to suggest to the States that they may, if they so desire, establish a differential rate for payments to the obstetricians and to general practitioners performing obstetrical services." 48 It was added that this opinion did not represent the final judgment of the Solicitor's office, but only current thinking.

Another interesting problem came up regarding the legal relationships of patient, physician, and state health department, and physician's liability for malpractice and breach of contract under the EMIC program. The Solicitor felt that if the bilateral contract for the rendition of services was considered to exist between the state and the physician and not between the patient and the physician it "would not only be unfortunate in practical effect, but

47 Memorandum from the Solicitor to Dr. Daily on the Michigan Medical Service and the Michigan EMIC Plan. April 19, 1944.
48 Memorandum from Peter Seitz, Department of Labor, to Dr. Elliot on Differential Rates of Payment for Certain Services Rendered by General Practitioners and by Specialists in the EMIC Program. June 19, 1944.
not in accord with my understanding of the legal relationship existing under the program. It would be unfortunate because it provides an opening for opponents of the program to contend that Government is contracting for medical care and services." Quoting the Solicitor at length on this question:

"The State agency does not enter into any contract with the physician for the performance of medical services. By 'authorizing' the care, it does no more than to agree that if the physician abides by the agreement entered into with the patient for medical services to be performed for her, it will compensate him in accordance with that agreement, on behalf of the patient.

"Thus, in terms familiar to the law, the physician is under a 'duty' (by reason of his express agreement with the patient) to perform medical services quantitatively described; he has an inchoate 'right' against the State (by reason of the 'authorization') to a fixed remuneration if he fulfills that obligation of the agreement; and the State owes 'duty' to him (by reason of the 'authorization') to remunerate him under those circumstances." In conclusion he states: "you will observe that in this triangular arrangement the only contract for the performance of medical services is entered into by the physician and the patient."49

In the question of malpractice, the Solicitor decided that even though the contract calls for "complete maternity care" the physician is no more liable to a malpractice suit than under ordinary circumstances since, "a malpractice claim does not arise out of a contract; the claim rests on a duty imposed by law on physicians." However, the patient might sue the physician for breach of contract if the services listed are not rendered.

49Memorandum from the Solicitor to Miss Lenroot on the Legal Relationships of Patients, Physicians, and State Health Agency under the EMIC Programs. June 28, 1944.
At a meeting of a small group of obstetricians, including several members of the Maternal and Child Health Advisory Committee, called by the Children's Bureau on June 5, 1944, a question arose as to whether the scope of liability for malpractice is enlarged when a physician agrees to perform the medical services authorized under the EMIC program. The contention was made by one of the physicians present that a physician who requests authorization under the program enters into an agreement to perform all the services called for by the authorization and consequently takes upon himself liabilities not ordinarily imposed by law. The Children's Bureau wanted to know whether the enhanced liability in question might arise both in an action for breach of contract as well as in a negligence suit for malpractice.

The opinion of the Solicitor was as follows: "Malpractice is a common law liability and the standard of care required is completely independent of any agreement made by the physician.

"...there is nothing in the agreement entered into by a physician to perform the services authorized under the EMIC program which calls for the exercise of more than average care and diligence. The physician may depart, in some particular, from the prescribed treatment, in the exercise of his judgment, but such omission would not render him any more liable for negligence than if he had so departed in treating a private case. Such departure might give rise to a technical violation of a contract; but clearly, it would have to be shown in a suit based on contract (as well as a suit in negligence) that the omission was the proximate cause of some harm that otherwise might have been avoided."50 The Solicitor believed,

50 Memorandum from the Solicitor to Miss Lenroot on Physicians' Liability for Malpractice and Breach of Contract under the EMIC Program. July 5, 1944.

Provided by the Maternal and Child Health Library, Georgetown University
however, that the contract liability of the physicians may be enlarged under the program, because they are asked to give a greater quantity of services for maternity cases than many of them ordinarily render.
Prior to March, 1943 the month in which the first appropriation for EMIC was approved by Congress, 28 states were already operating maternity and infant care programs for wives and infants of servicemen on a small scale. Many of these states, however, had exhausted or were exhausting their funds. After the inauguration of EMIC the states submitted their programs and estimates of need for funds for approval by the Children's Bureau. The great demand for funds is indicated by the speed by which the states came forward with plans:

Table 1

<table>
<thead>
<tr>
<th>Month and Year</th>
<th>Number of States* Whose Plans Were Approved in Specified Month</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1943</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>May</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>June</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>July</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>August</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>September</td>
<td>2</td>
<td>47</td>
</tr>
<tr>
<td>October</td>
<td>0</td>
<td>47</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>December</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>1944</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>0</td>
<td>50</td>
</tr>
<tr>
<td>February</td>
<td>1</td>
<td>51</td>
</tr>
<tr>
<td>March</td>
<td>1</td>
<td>52</td>
</tr>
</tbody>
</table>

*Includes the 48 states and Alaska, Hawaii, Puerto Rico and the District of Columbia.

Beginning with a few hundred maternity cases in the state of Washington in 1941, the monthly average new case load throughout the nation rose to a peak of over 42,000 maternity cases by June, 1944, and thereafter began to decline. In November, 1946 the new
maternity case load was only about 8,000 (Fig. 1#). The total
number of maternity cases authorized for care through November,
1946 was over 1,160,000; the number of infants authorized for care
over 128,700. Through November, 1946, New York State alone autho-
ized care for 100,407 maternity cases and California for 92,424.
The eight states selected for an administrative analysis authorized
care for almost 400,000 maternity cases or one-third of the national
total.

The Children's Bureau estimated that about 85 percent of the
maternity cases eligible for care under the EMIC program applied
for the services. It is also estimated that at the height of the
program one out of every seven births in the United States was
cared for under the program. A study in Nebraska revealed that by
1946 slightly over 83 percent of births to servicemen's wives were
cared for by EMIC; and 16 percent of all births in the state were
under EMIC.¹

In the country as a whole the cost per case for maternity
care rose from $72.73 in the period from the beginning of the pro-
gram through February, 1944 to $103.11 for cases completed in
August, 1946 and fell slightly to $100.84 for cases completed in
November of the same year (Fig. 2**). Of the eight states included
in this study the highest cost was experienced in New York where

* See Appendix, Table 1.
** See Appendix, Table 2.
¹ Roland H. Loder, An Analysis of the Administrative
Development; Procedures and Certain Statistical Trends in the
Emergency-Maternity-Infant-Care Program for Servicemen's Families
Arbor, School of Public Health, University of Michigan, June, 1946.
Table IX, p. 51.
FIGURE 1

MATERNITY AND INFANT CARE

Trend in Number of Cases Authorized, April, 1943 - December, 1946

- Total Cases (5-month moving average)
- Maternity Cases (5-month moving average)
- Infant Cases (5-month moving average)
- Estimate

Federal Security Agency - Social Security Administration - U.S. Children's Bureau

Provided by the Maternal and Child Health Library, Georgetown University
the cost per maternity case was $91.39 for cases completed from the
beginning of the program in that state through February, 1944 and
rose to $133.24 for cases completed in August, 1946. A more moder-
ate cost state was Michigan in which the cost rose from $82.11 to
$117.71 for maternity cases completed during the same period. In
Georgia, a low cost state, maternity costs rose from $47.86 for
cases completed from the beginning of the program in that state
through February, 1944 to $89.63 for cases completed in May, 1946,
and by November, 1946 the cost of completed maternity cases dropped
to $84.03.

These figures represent the entire cost for all maternity
services purchased under the EMIC program. The breakdown by types
of care provided under the program reveals that physicians' ser-
dices and hospital services make up the major portion of the cost;
about 2 percent of the total cost represents other types of services
such as consultation, bedside nursing, care in clinics, drugs, am-
bulance, and blood for transfusions. The data for the breakdown
by type of service were available quarterly beginning March 31,
1944, while the data for the total cost for maternity cases were
available monthly beginning March, 1944.

Table 2 below gives figures on the average cost for physicians' services for completed maternity cases. The average has been com-
puted on the basis of the total number of completed cases for whom
any type of care was purchased. The table reveals that the cost
per maternity case for physicians' services nation wide rose from
$32.89 in the quarter ending March 31, 1944, to $43.62 in the
quarter ending June 30, 1946. The cost for hospital care per ma-
ternity case rose from $40.72 to $52.31 during the same period.
The variations in the cost of physicians' services per maternity case among the eight states included in this study are also revealed in Table 2.

Table 2

Average Cost of Physicians' Services for Maternity Cases Completed in the Quarters Ending March 31, 1944 and June 30, 1946 for the United States and Selected States

<table>
<thead>
<tr>
<th>State</th>
<th>Quarter Ending March 31, 1944</th>
<th>Quarter Ending June 30, 1946</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$32.89</td>
<td>$39.05</td>
</tr>
<tr>
<td>California</td>
<td>32.45</td>
<td>39.05</td>
</tr>
<tr>
<td>Georgia</td>
<td>20.17</td>
<td>42.91</td>
</tr>
<tr>
<td>Illinois</td>
<td>28.85</td>
<td>48.28</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>33.21</td>
<td>42.33</td>
</tr>
<tr>
<td>Michigan</td>
<td>34.16</td>
<td>46.41</td>
</tr>
<tr>
<td>Mississippi</td>
<td>30.67</td>
<td>41.82</td>
</tr>
<tr>
<td>Nebraska</td>
<td>33.81</td>
<td>44.61</td>
</tr>
<tr>
<td>New York</td>
<td>41.91</td>
<td>48.99</td>
</tr>
</tbody>
</table>

a/ Estimated

It will be noted that in the quarter ending March 31, 1944 of the eight states studied the lowest state had an average cost for physicians' services of $20.17 per maternity case and the highest state $41.92, a range of $21.75. Over two years later in June, 1946 the lowest average cost was $39.05, the highest $48.99, a range of $9.94. A national program tends to standardize fees even though at first the Children's Bureau attempted to promote state variations according to average prevailing physicians' fees for maternity care, but later left to the states the decision as to whether the medical fee paid should or should not be the maximum rate ($50) authorized by the bureau for complete maternity care.
The variations in the average cost of hospital care per completed maternity case is shown in table 3 below:

Table 3
Average Cost of Hospital Care for Maternity Cases Completed in the Quarters Ending March 31, 1944 and June 30, 1946 for the United States and Selected States

<table>
<thead>
<tr>
<th>State</th>
<th>Quarter Ending March 31, 1944</th>
<th>Quarter Ending June 30, 1946</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$40.72</td>
<td>$52.31</td>
</tr>
<tr>
<td>California</td>
<td>55.49a/</td>
<td>63.78</td>
</tr>
<tr>
<td>Georgia</td>
<td>29.83</td>
<td>42.13</td>
</tr>
<tr>
<td>Illinois</td>
<td>46.60a/</td>
<td>59.39</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>40.42</td>
<td>57.02</td>
</tr>
<tr>
<td>Michigan</td>
<td>50.17</td>
<td>63.41</td>
</tr>
<tr>
<td>Mississippi</td>
<td>26.83</td>
<td>38.73</td>
</tr>
<tr>
<td>Nebraska</td>
<td>37.94</td>
<td>41.70</td>
</tr>
<tr>
<td>New York</td>
<td>44.56</td>
<td>63.50</td>
</tr>
</tbody>
</table>

a/ Estimated

As in the case of the cost of physicians' services shown in table 2, the average costs presented in table 3 are based on the total number of completed maternity cases for whom any type of care was purchased. The figures are therefore lower than they would be if the average were based only on the number of maternity cases receiving hospital care. The figures in both tables 2 and 3 do not include payments to hospitals where a single combined payment was made to a hospital for both hospital care and physicians' services. However, by using the average cost based on all cases, the distribution of the total cost among the types of services can be seen.
The average payments per day for hospital care are presented in Table 4:

Table 4
Average Per Diem Payments for Hospital Care for Maternity Cases Completed in the Quarters Ending March 31, 1944 and June 30, 1946 for the United States and Selected States

<table>
<thead>
<tr>
<th>State</th>
<th>Quarter Ending March 31, 1944</th>
<th>Quarter Ending June 30, 1946</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>$5.38</td>
<td>$6.58</td>
</tr>
<tr>
<td>California</td>
<td>7.76</td>
<td>8.38</td>
</tr>
<tr>
<td>Georgia</td>
<td>4.46</td>
<td>6.65</td>
</tr>
<tr>
<td>Illinois</td>
<td>5.55</td>
<td>6.64</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>5.23</td>
<td>6.61</td>
</tr>
<tr>
<td>Michigan</td>
<td>6.22</td>
<td>7.67</td>
</tr>
<tr>
<td>Mississippi</td>
<td>4.36</td>
<td>6.03</td>
</tr>
<tr>
<td>Nebraska</td>
<td>4.85</td>
<td>5.14</td>
</tr>
<tr>
<td>New York</td>
<td>6.19</td>
<td>7.43</td>
</tr>
</tbody>
</table>

These figures do not necessarily represent the actual per diem cost of the hospitals, but the average payment to hospitals by the states in accordance with the policies and procedures established by the Children's Bureau. During most of this period hospital care was purchased on a cost per patient day basis as determined by cost-accounting reports of the participating hospitals taking into consideration the proportion of multiple-bed accommodations and subject to the maximum established per diem rates. Customarily, if no agreement was reached, the state paid a flat per diem rate. These figures do not show the range within states within which there may be considerable variation.

The cost for hospital and physicians' services per infant case fluctuates greatly from month to month and from state to state.

due in part to the small number of infant cases completed in some states. Also, the programs varied greatly from state to state in terms of number of cases, demand for services, and type or kind of service provided. California and New York authorized care for 6,494 and 28,202 infants respectively from the beginning of the program through November 30, 1946. Michigan authorized care for 7,106 and Georgia 1,508 infants from the beginning of the EMIC program through November, 1946. During this period in California the monthly average cost per completed infant case ranged between $33.10 and $123.07. In Georgia with a lower average cost than California the cost per completed infant care ranged between $10.26 and $147.27.

The effect of the EMIC program on the percent of births in hospitals is clearly evident in Table 5. The states with a high percent of births in hospitals, such as New York and California, could not go much higher, but states like Nebraska and Georgia show a great increase in the percentage of hospital deliveries.

Table 5

<table>
<thead>
<tr>
<th></th>
<th>Quarter Ending March 31, 1944</th>
<th>Quarter Ending June 30, 1946</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Home</td>
<td>Hospital</td>
</tr>
<tr>
<td>United States</td>
<td>89.8</td>
<td>94.1</td>
</tr>
<tr>
<td>California</td>
<td>98.9</td>
<td>99.3</td>
</tr>
<tr>
<td>Georgia</td>
<td>75.9</td>
<td>86.8</td>
</tr>
<tr>
<td>Illinois</td>
<td>97.7</td>
<td>98.0</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>99.6</td>
<td>98.6</td>
</tr>
<tr>
<td>Michigan</td>
<td>95.6</td>
<td>97.4</td>
</tr>
<tr>
<td>Mississippi</td>
<td>74.6</td>
<td>79.7</td>
</tr>
<tr>
<td>Nebraska</td>
<td>71.4</td>
<td>94.9</td>
</tr>
<tr>
<td>New York</td>
<td>99.0</td>
<td>98.9</td>
</tr>
</tbody>
</table>

The EMIC program also reveals the very high percent of deliveries attended by doctors of medicine in contrast to osteopaths and others. Fully 97 percent of the births were attended by licensed
doctors of medicine, around 2.5 percent by osteopaths; the remainder by others or were not reported.

In summary: Whatever may be the final evaluation of the EMIC program it should be emphasized that in the short span of time from April, 1943 to late in 1946 over 1,000,000 babies were born under the program; physicians and hospitals were paid, and almost $121,000,000 were allotted to the states for the care of EMIC cases and the administration of the program. All this was accomplished as an emergency program by administrative agencies already in existence with a shortage of administrative personnel, and hardly any additional funds provided for administration. In addition there was a shortage of physicians and hospital beds. In spite of the complaints that were plentiful, there must have been a great deal of cooperation from physicians, hospitals, nurses, administrative agencies, and others to have accomplished this tremendous task.
### Table 1

Number of Maternity and Infant Cases Authorized in the United States from Beginning of Program through November, 1946

<table>
<thead>
<tr>
<th>Month</th>
<th>Maternity</th>
<th>Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,163,571</td>
<td>189,740</td>
</tr>
<tr>
<td>April, 1943 through February 29, 1944</td>
<td>229,960</td>
<td>-</td>
</tr>
<tr>
<td>1944 March</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>37,204</td>
<td>3,897</td>
</tr>
<tr>
<td>May</td>
<td>41,768</td>
<td>4,418</td>
</tr>
<tr>
<td>June</td>
<td>42,547</td>
<td>4,197</td>
</tr>
<tr>
<td>July</td>
<td>37,095</td>
<td>3,690</td>
</tr>
<tr>
<td>August</td>
<td>41,578</td>
<td>4,422</td>
</tr>
<tr>
<td>September</td>
<td>33,668</td>
<td>4,393</td>
</tr>
<tr>
<td>October</td>
<td>36,774</td>
<td>4,831</td>
</tr>
<tr>
<td>November</td>
<td>35,229</td>
<td>5,604</td>
</tr>
<tr>
<td>December</td>
<td>27,235</td>
<td>4,788</td>
</tr>
<tr>
<td>1945 January</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>34,217</td>
<td>6,053</td>
</tr>
<tr>
<td>March</td>
<td>29,678</td>
<td>5,902</td>
</tr>
<tr>
<td>April</td>
<td>31,431</td>
<td>7,070</td>
</tr>
<tr>
<td>May</td>
<td>37,257</td>
<td>6,805</td>
</tr>
<tr>
<td>June</td>
<td>32,567</td>
<td>5,737</td>
</tr>
<tr>
<td>July</td>
<td>31,544</td>
<td>5,542</td>
</tr>
<tr>
<td>August</td>
<td>30,994</td>
<td>5,153</td>
</tr>
<tr>
<td>September</td>
<td>30,402</td>
<td>5,363</td>
</tr>
<tr>
<td>October</td>
<td>32,340</td>
<td>6,297</td>
</tr>
<tr>
<td>November</td>
<td>28,007</td>
<td>5,452</td>
</tr>
<tr>
<td>December</td>
<td>23,639</td>
<td>4,866</td>
</tr>
<tr>
<td>1946 January</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>26,538</td>
<td>5,598</td>
</tr>
<tr>
<td>March</td>
<td>24,583</td>
<td>5,011</td>
</tr>
<tr>
<td>April</td>
<td>26,502</td>
<td>6,056</td>
</tr>
<tr>
<td>May</td>
<td>24,230</td>
<td>5,843</td>
</tr>
<tr>
<td>June</td>
<td>21,716</td>
<td>5,771</td>
</tr>
<tr>
<td>July</td>
<td>18,321</td>
<td>5,177</td>
</tr>
<tr>
<td>August</td>
<td>15,780</td>
<td>5,140</td>
</tr>
<tr>
<td>September</td>
<td>14,158</td>
<td>4,941</td>
</tr>
<tr>
<td>October</td>
<td>11,320</td>
<td>4,720</td>
</tr>
<tr>
<td>November</td>
<td>10,443</td>
<td>5,185</td>
</tr>
<tr>
<td></td>
<td>7,888</td>
<td>4,716</td>
</tr>
</tbody>
</table>

---

*Includes the 48 states, the District of Columbia, Alaska, Hawaii, and Puerto Rico.*

*These figures differ from the sums of the individual items because of changes in the cumulative totals submitted by some state agencies without corresponding changes in the monthly figures.*

*c/ Includes infant cases, which represent only a small proportion of the total.*
### Table 2: Average Cost of Completed Cases in the United States from Beginning of Program through November, 1946

<table>
<thead>
<tr>
<th>Month</th>
<th>Maternity</th>
<th>Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through February 29, 1944</td>
<td><strong>$72.78</strong></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>78.87</td>
<td>35.45</td>
</tr>
<tr>
<td>April</td>
<td>79.25</td>
<td>36.65</td>
</tr>
<tr>
<td>May</td>
<td>81.73</td>
<td>44.02</td>
</tr>
<tr>
<td>June</td>
<td>82.16</td>
<td>39.51</td>
</tr>
<tr>
<td>July</td>
<td>84.27</td>
<td>43.91</td>
</tr>
<tr>
<td>August</td>
<td>85.43</td>
<td>42.47</td>
</tr>
<tr>
<td>September</td>
<td>83.87</td>
<td>55.11</td>
</tr>
<tr>
<td>October</td>
<td>84.80</td>
<td>48.36</td>
</tr>
<tr>
<td>November</td>
<td>87.31</td>
<td>48.06</td>
</tr>
<tr>
<td>December</td>
<td>88.45</td>
<td>52.99</td>
</tr>
<tr>
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<td>November</td>
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</tr>
</tbody>
</table>

**a/** Includes the 48 states, the District of Columbia, Alaska, Hawaii, and Puerto Rico.

**b/** Includes infant cases, which represent only a small proportion of total.
APPENDIX

Form M (March 29, 1943) State Health Agency
Division of Maternal and Child Health

Emergency Maternity and Infant Care Program

APPLICATION FOR MATERNITY CARE

Patient's name __________________________ Date of birth____________________
( Last) (First) (Middle)

Present address __________________________ (Street) ______________________
(City) ____________________________ Tel. No. ______________________
(County) (State)

Name of husband __________________________ (Last) (First) (Middle)

Branch of service __________________________ (Army, Navy, Marine Corps, Coast Guard)

Rank or rating __________________________ Husband's serial no. ______________________

Husband's service mailing address __________________________

On the basis of the above facts, I am requesting maternity care under the Emergency Maternity and Infant Care Program of the State health agency.

Signature of patient __________________________ Date signed ______________________

Note: Any woman is eligible for care, irrespective of legal residence or financial status, whose husband is an enlisted man in the armed forces of the United States (Army, Navy, Marine Corps, or Coast Guard) of the fourth, fifth, sixth, or seventh grades. (This excludes families of commissioned officers; master, major, first technical, staff, and platoon sergeants; chief, first, and second-class petty officers.)

Only maternity care rendered by physicians or hospitals meeting the qualifications or standards established by the State health agency can be authorized.
REQUEST FOR AUTHORIZATION FOR MEDICAL OR HOSPITAL SERVICE
FOR MATERNITY CASES

(To be filled out by private or clinic physician)

Month of pregnancy: ___________________

Expected date of confinement: __________

Date patient given first physical examination by me during this pregnancy: ____________________

Delivery is recommended: At home __________ In hospital __________

Name of hospital recommended: __________________________________________________________

I request authorization for payment for the following services to be provided to this patient and the newborn infant in accordance with rates for payments, conditions and standards established by the State health agency. I agree not to accept payment from the patient or her family for services authorized.

Indicate below the services for which you request authorization:

Complete medical services including care during the prenatal period, labor, and the puerperium, as well as care of complications, obstetric operations if needed, postpartum care, care of the newborn infant, and a postpartum examination six weeks after delivery, routine blood test for syphilis, hemoglobin determinations, and urinalyses. __________________________ ( )

Medical services during labor and the puerperium including care of complications, obstetric operations if needed, postpartum care, care of newborn infant, and postpartum examination six weeks after delivery. __________________________ ( )

Hospital care for a period of not to exceed two weeks at a rate agreed upon between the hospital and the (State Health Agency). __________________________ ( )

Other, describe (see note below) __________________________

____________________________________________________________________________________

____________________________________________________________________________________

I have ascertained from the patient's allowance card or other data in her possession that the serial number is correct: Yes __________ No __________

Signature of attending physician: __________________________ Date: __________________________

Note: If necessary, authorization, if accompanied by supporting data, may also be requested for the following services for this patient: consultation by specialists, bedside nursing care, ambulance, un-usually expensive drugs or diagnostic procedures or for hospital care of longer than two weeks duration. When such authorization is requested, state the person, agency, or firm recommended to provide this service.

Authorization will not cover services rendered prior to the date of application except for emergencies.

This form should be sent by the attending physician or clinic to the Director, Division of Maternal and Child Health, State Health Agency.

Provided by the Maternal and Child Health Library, Georgetown University
Form M-1 (March 29, 1943)  
State Health Agency  
Division of Maternal and Child Health  
Emergency Maternity and Infant Care Program  
APPLICATION FOR MEDICAL OR HOSPITAL CARE FOR INFANT

<table>
<thead>
<tr>
<th>Child's name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last) (First) (Middle)</td>
<td></td>
</tr>
</tbody>
</table>

| Name of child's mother        |              |
| (Last) (First) (Middle)       |              |

| Mother's present address      | Tel. No.     |
| (Street) (City)              |             |
| (County) (State)             |             |

| Name of child's father        |              |
| (Last) (First) (Middle)       |              |

| Branch of service             |              |
| (Army, Navy, Marine Corps, Coast Guard) |           |

| Rank or rating                | Father's serial no. |
| (Relationship to child)       | (State)            |

On the basis of the above facts, I am requesting care for this child from the Emergency Maternity and Infant Care Program of the State health agency.

Signature ___________________________ Date signed ________________

(Relationship to child ___________________________)

Note: Any infant under one year of age is eligible for care, irrespective of legal residence or financial status, whose father is an enlisted man in the armed forces of the United States (Army, Navy, Marine Corps, or Coast Guard) of the fourth, fifth, sixth, or seventh grades. (This excludes families of commissioned officers; master, major, first, technical, staff, and platoon sergeants; chief first, and second-class petty officers.)

Only care rendered by physicians or hospitals meeting the qualifications or standards established by the State health agency can be authorized.
REQUEST FOR AUTHORIZATION FOR MEDICAL OR HOSPITAL CARE FOR INFANT

(To be filled out by private or clinic physician)

Physician's statement briefly describing child's illness

________________________________________________________________________

Date child first observed by me during this illness

I request authorization of payment for the professional services to be provided by me to the above-named child in accordance with rates for payments, conditions and standards established by the State health agency. I agree not to accept payment from the child's parent or family for services authorized.

I also request authorization for the following additional services--hospitalization, consultation, bedside nursing, unusually expensive drugs or diagnostic procedures--(specify name of individual or agency you wish to give such services or care):

Consultation by________________________ M.D., Specialist in________

Name of hospital recommended________________________

Other________________________

I have ascertained from the allowance card or other data in the parent's possession that the serial number is correct: Yes____ No____.

Signature of attending physician________________________ Date____

Note: Authorization can only be given for care of sick children requiring three or more home, office or hospital visits per week of illness. Initial authorization is not issued for a period of more than three weeks.

If necessary, authorization, if accompanied by supporting data, may also be requested for the following services for this patient: consultation by specialists, bedside nursing care, ambulance, unusually expensive drugs or diagnostic procedures or for hospital care of longer than two weeks duration. When such authorization is requested state the person, agency, or firm recommended to provide this service.

Authorization will not cover services rendered prior to the date of application except for emergencies.

This form should be sent by the attending physician or clinic to the Director, Division of Maternal and Child Health, State Health Agency.
APPENDIX

Form M-2 (March 29, 1943)  

State Health Agency  
Division of Maternal and Child Health  

Authorization No.__________  
Case No.__________  

Emergency Maternity and Infant Care Program  

AUTHORIZATION FOR SERVICES AND CARE  

Date__________  

To:_____________ (Person, agency, or firm)  

(Patient's name)  

(Address)  

(Patient's address)  

(Name of attending physician)  

This is to certify that the (State health agency) will assume responsibility for payment for the following services to be provided the above-named patient:  

(This space to be used for specifying the services authorized, period of time covered by the authorization, and rate to be paid by the State health agency.)  

The patient (or parent) has been notified that this authorization has been made effective as of ______________.  

(Date)  

Signature  

(Name and title of authorizing agent)  

Note: Invoices for physicians' services, when submitted to (Official's title) together with attending physician's final medical report, constitutes the basis for payment of services.  

(Copy of all authorizations should be sent to attending physician)
APPENDIX

Emergency Maternity and Infant Care Program
Estimates and Appropriations

1. Fiscal Year 1943
   Dec. 21, 1942 - Children's Bureau expressed need for $1,817,200
   Feb. 1, 1943 - Approved and sent to Congress 1,200,000
   Feb. 24, 1943 - House bill reported excluding item
   Feb. 26, 1943 - Keefe offered amendment on floor:
   lost on point of order 1,200,000
   Mar. 9, 1943 - Senate Committee offered amendment providing
   Mar. 12, 1943 - Senate passed amendment
   Mar. 15, 1943 - House agreed to Senate amendment
   Mar. 18, 1943 - Act approved

2. Fiscal Year 1944
   Apr. 24, 1943 - Children's Bureau expressed need for 6,000,000
   Apr. 13, 1943 - Approved and sent to Congress
   June 14, 1943 - House bill reported
   June 24, 1943 - Senate Committee recommended
   June 29, 1943 - Senate passed
   June 30, 1943 - Conferences approved
   July 12, 1943 - Act approved

3. Supplemental Appropriation Fiscal Year 1944
   Aug. 25, 1943 - Children's Bureau expressed need for 20,078,235
   (Includes 3% of $922,792 for State adm.)
   Sept. 16, 1943 - Approved and sent to Congress
   (Nothing for State administration)
   Sept. 22, 1943 - House J. Res. 159 reported
   Sept. 22, 1943 - House passed
   Sept. 24, 1943 - Senate Committee recommended
   Sept. 28, 1943 - Senate passed
   Oct. 1, 1943 - Act approved

4. Supplemental Appropriation Fiscal Year 1944
   Apr. 17, 1944 - Children's Bureau expressed need for 6,783,531
   Apr. 29, 1944 - Approved and sent to Congress
   May 3, 1944 - House J. Res. 271 reported
   May 5, 1944 - House passed
   May 9, 1944 - Senate passed
   May 12, 1944 - Act approved
5. Fiscal Year 1945

Oct. 5, 1943 - Children's Bureau expressed need for.......................... $24,100,000
Jan. 10, 1944 - Approved and sent to Congress(H.Doc.561).................. 20,000,000
Mar. 31, 1944 - President sent to Congress amended language to include army aviation cadets, not more than 4% for State administration, and appropriation to be immediately available..............................

Apr. 20, 1944 - Supplemental request for 1945 by Children's Bureau for................................................. 22,810,400
(Not more than 45 or $1,630,000 for State administration)

Apr. 29, 1944 - Approved and sent to Congress........................................ 22,800,000
May 27, 1944 - House bill reported.................................................. 42,800,000
(2% for State administration; excluded army aviation cadets)

June 1, 1944 - House passed............................................................ 42,800,000
(2% for State administration; excluded army aviation cadets)

June 13, 1944 - Senate Committee reported........................................ 42,800,000
(3% for State administration; included army aviation cadets)

June 15, 1944 - Senate passed.......................................................... 42,800,000
(3% for State administration; included army aviation cadets)

June 21, 1944 - Conference report................................................... 42,800,000
(2% for State administration; included army aviation cadets)

June 22, 1944 - House agreed to Conference report.............................. 42,800,000
June 23, 1944 - Senate agreed to Conference report.............................. 42,800,000
June 28, 1944 - Act approved.......................................................... 42,800,000
(2% for State administration; included army aviation cadets)

6. Supplemental Appropriation Fiscal Year 1945

May 14, 1945 - Children's Bureau expressed need for.......................... 2,547,965
May 22, 1945 - Approved and sent to Congress.................................... 2,300,000
June 5, 1945 - H.J.Res.212 reported.............................................. 2,200,000
June 6, 1945 - House passed.......................................................... 2,200,000
June 7, 1945 - Senate Committee reported........................................ 2,200,000
June 8, 1945 - Senate passed.......................................................... 2,200,000
June 12, 1945 - Act approved.......................................................... 2,200,000

7. Fiscal Year 1946

Oct. 7, 1944 - Children's Bureau expressed need for.......................... 44,189,500
Jan. 9, 1945 - Approved and sent to Congress.................................... 44,189,500
(2½%, or $1,104,737.50 for State administration)

May 14, 1945 - House bill reported................................................ 44,189,500
May 17, 1945 - House passed.......................................................... 44,189,500
June 23, 1945 - Senate committee reported..................................... 44,189,500
July 3, 1945 - Act approved............................................................ 44,189,500
8. Fiscal Year 1946 - Reductions in Wartime Appropriations, including EMIC

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>Aug. 28, 1945</td>
<td>Children's Bureau report to House Appropriation Committee indicated need for retaining all</td>
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<tr>
<td>Sept. 15, 1945</td>
<td>President sent to Congress H.Doc.280 recommending reductions in certain wartime appropriations</td>
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<tr>
<td>Oct. 2, 1945</td>
<td>Children's Bureau stated at hearing before House Appropriation Committee that appropriation</td>
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<tr>
<td></td>
<td>could be reduced by $8,113,600 leaving available $36,075,900 (including 2%, or $1,104,737</td>
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<tr>
<td>Oct. 17, 1945</td>
<td>House reported showing subsequent rescission recommended(H.R.4407)</td>
</tr>
<tr>
<td>Oct. 19, 1945</td>
<td>House passed reduction</td>
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<tr>
<td>Nov. 14, 1945</td>
<td>Senate Appropriations Committee reported with reduction(H.R.4407)</td>
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<td>Nov. 20, 1945</td>
<td>Senate passed reduction</td>
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<td>Dec. 22, 1945</td>
<td>President vetoed H.R.4407 and announced transfer to unexpendable reserves rescission amounts</td>
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<td>Feb. 18, 1946</td>
<td>Act approved reducing 1946 appropriation by</td>
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Supplemental Appropriation Fiscal Year 1946

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<td>Apr. 26, 1946</td>
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<td>May 3, 1946</td>
<td>Approved and sent to Congress(H.Doc.554)</td>
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<td>House bill reported</td>
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<td>House passed</td>
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<td></td>
<td>Senate passed</td>
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<td>June 21, 1946</td>
<td>Act approved</td>
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10. Fiscal Year 1947

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<td>Oct. 8, 1945</td>
<td>Children's Bureau expressed need for</td>
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<td>Nov. 6, 1945</td>
<td>Revised estimate by Children's Bureau on date of hearing for</td>
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<td>President sent to Congress</td>
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<td>March 4, 1946</td>
<td>Estimate by Children's Bureau for study of experience under EMIC program</td>
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<tr>
<td>Apr. 29, 1946</td>
<td>President sent to Congress request for amending grants language to provide $929,000 of $17,593,000</td>
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<tr>
<td>July 26, 1946</td>
<td>Act approved</td>
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