A Half Century of Pioneering for Child Health

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IN 1912 when the Children's Bureau was established by act of Congress the infant mortality rate, a sensitive thermometer of the health status of a people, was 100 deaths or more (under 1 year of age) per 1,000 live births. Fifty years later, in 1962, it probably will be 25 deaths per 1,000. If the rate of 1912 prevailed today, about 428,000 babies would die during the 50th anniversary year of the Children's Bureau. Instead, the loss will be about 107,000. Equally striking figures could be quoted for the drop in maternal mortality. Today few women die in childbirth, and the true orphan, deprived of parental care by death of parents, is rare indeed.

Many factors have contributed to this phenomenal change, and no one agency or program or discovery can take total credit. A higher standard of living, upgrading of medical education, clean milk and water, more effective control of the common housefly, more and better hospitals, rapid transportation, the growth of the mass media, and the citizen's increased knowledge of health are some of the many changes in American life in the last half century that have produced this favorable response in maternal and child health.

But to the Children's Bureau should go some of the credit for many of these advances, since infant and maternal mortality studies represent the Bureau's longest continuous and consistent effort to investigate and report to the people and to the Congress upon a specific condition affecting children's well-being as well as the Bureau's earliest service program for mothers and children.

On the occasion of the 50th anniversary of the Children's Bureau it is appropriate to look in some detail, with the perspectives of 1960, at the unique role the Bureau has played in its efforts to improve the well-being of American children. Agencies, like people, have certain characteristics, derived from their purpose and molded by their leaders. From its beginning in 1912 the Children's Bureau has been an action agency. Established to investigate and report "upon all matters pertaining to the welfare of children and childlife among all classes of our people," the Bureau interpreted this mandate, as was clearly the intent of the Congress as revealed in the hearings for the basic act, to mean the establishment of facts for the purpose of stimulating action for children. Its first studies, on the social and environmental factors

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contributing to infant mortality and maternal mortality, produced a body of facts on which social action could be taken. These studies produced facts that led directly to congressional action in 1921 aimed at improving maternal and child health.

"Pioneering" should be coupled with the word "action" to describe the Children's Bureau program, for many of its activities have been firsts. The Maternity and Infancy Act, familiarly known as the Sheppard-Towner Act, was an early example of action to improve the care of infants and mothers during childbearing. In 1917, Julia Lathrop, the Bureau's first chief, saw the possibilities of adapting Federal grants-in-aid to States, then used for public roads and agriculture, to meet the health needs of mothers and infants. After a long and arduous campaign, conducted chiefly by organized women, the Maternity and Infancy Act was passed late in 1921. The act strengthened State and local public health services for mothers and children and brought to mothers, especially in the smaller towns and cities, knowledge about good maternity care as well as infant and preschool child care. Though the Maternity and Infancy Act expired in June 1929, much was learned from it which proved of great value when the Congress in 1935 reestablished under the Social Security Act the program of aid to the States for maternal and child health.

A second pioneering program for which the Children's Bureau laid the groundwork in the twenties was the crippled children's services which were included in the Social Security Act of 1935. This program has many unique characteristics. It was the first Federal-State venture in medical care, and as such offered the Bureau an opportunity to develop with the States policies and procedures that had a far-reaching effect on many health programs. It provided for crippled children's comprehensive medical care. The act required States to include in their programs services for finding children who were crippled or suffering from diseases that might lead to crippling and to provide them with medical, surgical, and corrective services and care, and facilities for diagnosis, hospitalization, and aftercare. The act itself contains no definition of a crippled child and puts no limit on the types of crippling conditions a State can include in its plan, leaving the way open for broad programs. The States can also use funds for ill children in danger of becoming crippled.

The administration of the crippled children's program has been guided by two principles: that a public medical care program can be and should be of high quality, and that the program should broaden its scope and coverage as research produces means for treatment of handicapping conditions and as highly qualified personnel become available. From an orthopedic program in the beginning, the crippled children's program has broadened to include a wide variety of handicapping conditions. Rheumatic fever was included as a handicapping condition in 1939 and today, as a result of medical advances and of services to make these advances available, rheumatic fever is on the decline as a public health problem of childhood. Epilepsy and congenital heart disease are other examples of handicapping conditions which the crippled children's programs have incorporated as soon as medical advances made their attack possible.

Still another pioneering activity for which the Children's Bureau was responsible was the emergency maternity and infant care program during World War II. Operating from 1943 to 1948, the EMIC program provided complete maternity care for the wives of servicemen in the four lowest pay grades without cost, as well as health supervision and medical care for their infants up to 1 year of age. Though this program was in existence for only a few years, it met a great emergency need and it provided a laboratory for developing administrative techniques which have proved useful in other medical care programs.

Inevitably, a pioneering agency will find some of its ideas ahead of the times, and thus impractical. Ideas once considered radical may appear, in another form and under other auspices at a later date, as acceptable programs. One example of such delayed action is child health research. Stimulated by the Children's Bureau following World War II, legislation was introduced into the Congress for a comprehensive program of grants for research in childlife, but no action was taken. Today, 13 years later, legislation for the same purpose, provid-

ing for an Institute of Child Health and Human Development at the National Institutes of Health is before the Congress. Similarly, with the development of the Salk vaccine and the success of the field trials an all-out campaign was advocated by the Children's Bureau to put this important discovery to work. Today the President proposes a mass immunization campaign against diphtheria, tetanus, whooping cough, and poliomyelitis. Had child health research been given adequate support a decade ago, could we have prevented the rise in infant mortality which occurred in 1957 and 1958? If the Salk vaccine had been provided for all children in 1955, could we have prevented the 23,801 cases of paralytic poliomyelitis occurring in the intervening years?

The contribution of the Children's Bureau to maternal and child health has been not only in new programs to meet emerging needs, but in the administrative and program policies which have shaped its programs and contributed to high quality of service in public programs. Profoundly affecting the progress and the quality of maternal and child health and crippled children's services was the early decision to "reserve" a portion of fund B (the half of the appropriation which the States do not have to match) in order to provide for special projects of regional and national significance. This Reserve Fund B has made possible pioneering by the States to try out new methods and develop new and exciting programs. Most of the new programs got started in this way. Rheumatic fever was the first, with special project grants made to a number of States beginning in 1939. Later these programs were absorbed by the States under their regular programs. Special project grants to five States provided regional centers for evaluation and treatment of congenital heart disease, when operative treatment for this condition became possible. Most States now have facilities in which children with operable heart conditions can be cared for through regular funds. The epilepsy program started with a special project grant in 1 State, and now 31 States have such service. In 1956, when virtually nothing was being done by State health departments for mentally retarded children, the Congress earmarked $1 million for this purpose. Today 46 States have such programs in operation. The kinds of special projects States have undertaken are many—speech and hearing, medical services for migrant children, medical care for unmarried mothers, and a host of others. The value of this method of program stimulation which the Children's Bureau developed is reflected in its subsequent incorporation in programs of other agencies.

An emphasis on training as a program policy has proved valuable over the years. The Children's Bureau was the first to use Federal funds for this purpose, beginning in 1922 when it provided training for nurses under the Sheppard-Towner Act. In 1947 the first training grant to a school of public health, a special project grant, was made by the Bureau for the teaching of maternal and child health. In its health programs the Bureau has always encouraged States to be liberal in policies on training and to encourage the maximum use of funds for training of health personnel in all fields, for both long-term and refresher courses.

An early decision by the Bureau to support the integration of maternal and child health services into basic public health services proved to be a sound one. Though retaining their identity, these services have taken their place in a total community plan. Their identity, effectiveness, and quality have been maintained through adequate maternal and child health supervision and consultation.

Basic to the concept of what constitutes a good maternal and child health or crippled children's service is the team approach which developed early in these programs. To make the team complete, the Children's Bureau encouraged the development of medical-social and nutrition consultation in State health and crippled children's agencies. Most crippled children's agencies and many State health departments now have consultants from these two disciplines, and, when needed, other special members of the team, such as physical therapists, speech and hearing specialists, and psychologists, are added.

In arriving at policy decisions the Children's Bureau has made good use of advisory groups, sometimes technical, somtimes lay and technical. The advice of these groups, especially at the beginning of a program, has been invaluable. These advisory groups have not only

helped develop policy and advance quality of services but they also have been a medium for interpreting policies to the professional groups and to the public.

Its decisions on forward-looking program policy have been possible for the Bureau because its legislative base is so broad. Both basic laws under which the Children's Bureau operates are couched in broad language which makes great flexibility possible. The Basic Act of 1912 is a one-page document which establishes the Bureau and directs it to investigate and report "upon all matters pertaining to the welfare of children and childlife" and follows this with certain examples, such as infant mortality, the birth rate, accidents, and diseases of children. Title V of the Social Security Act is also broad in stating its purpose to assist the States to extend and improve their health and welfare services for children. The absence of limiting language has been conducive to growth of program in content, in quality, and in scope.

Fund B, the unmatched portion of the appropriation which relates to the financial capacity of the State to carry out its plan, has made possible the allotment of funds in a fashion which tends to equalize the great disparity between the States.

The flexibility and variation possible in State programs is a great asset. These health programs for children are State programs, built on the principle of Federal assistance to help States develop their own programs. There is no overall Federal plan which States must meet. Each State assesses its own needs and meets them in its own way. Progress made by the States over the years is proof that this principle is sound.

The greatest asset of the health programs for children is their setting in an administrative structure which combines health and welfare and which takes into account the social and environmental influences on health. Child health is but one facet of childlife.

Though the idea of a Children's Bureau may seem to some people to be an administrative anomaly, it is a philosophical truth which 50 years of experience has proved to be of great value to the children the Bureau seeks to serve.

Courses for Sanitary Engineer Reserve Officers

The annual advanced active-duty training session for sanitary engineering reserve officers in the Public Health Service, Army, Navy, and Air Force will be held June 3–16, 1962. The session is conducted by the Public Health Service's Robert A. Taft Sanitary Engineering Center in Cincinnati, Ohio.

Four courses will be offered: recent developments in water bacteriology, source sampling for atmospheric pollutants, environmental radiation surveillance, and emergency and disaster measures.

Public Health Service officers may apply for call to active duty for this training by contacting the associate director for environmental health services (regional engineer) in their Service regions. Sanitary engineer reserve officers in the Army, Navy, and Air Force should apply through the appropriate channels of each Service. Since the number of officers that will be accepted from each Service is strictly limited, early application is advisable.

Detailed information about the session is contained in a brochure available from the Chief, Training Program, Sanitary Engineering Center, Cincinnati 26, Ohio. Also available is the "Training Program Bulletin" containing schedules and descriptions of all courses conducted by the Training Program of the Center.