

THE CREATION OF FEDERAL SERVICES  
FOR CRIPPLED CHILDREN, 1890-1941

by

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A DISSERTATION

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## ABSTRACT

This historical study examines the factors that led to the creation of a federal program of services for crippled children in the United States during the 1930s. Established as part of the Social Security Act (SSA) of 1935, the Crippled Children Services (CCS) program was one of the first medical programs for children supported by the federal government. As early as the 1890s, many state and local governments developed services for crippled children through private and public efforts, making the federal government a relative late comer to supporting the needs of children with significant physical handicaps due to disease, birth defects and accidents. The development of a national reform agenda based on state and local efforts for crippled children began during the Progressive Era and culminated during the New Deal Era with the passage of the SSA. Several factors influenced the creation of the federal CCS program including the role of reformers and professional groups, the role of state-level private charities and children's institutions, and the increasing authority of the federal government in social programs. Under the SSA, states and territories quickly developed state-level CCS programs during the late 1930s. The United States Children's Bureau (USCB) administered the program for the federal government and helped states to incorporate preventive services and interdisciplinary approaches to service provision into state-level CCS programs. Factors that influenced the implementation of these programs included the availability of matching state funds, the establishment of state programs for crippled children prior to the SSA, and the accessibility of qualified health care professionals and facilities. The United States entry into World War II in 1941 slowed the growth of state-level CCS programs until 1945, and serves as a natural end point to this study.

## LIST OF ABBREVIATIONS

ADC	Aid to Dependent Children
ADAH	Alabama Department of Archives and History
ASCC	Alabama Society for Crippled Children
AAMSW	American Association of Medical Social Workers
ACHA	American Child Hygiene Association
ACS	American College of Surgeons
AMA	American Medical Association
AOA	American Orthopaedic Association
ASTHO	Association for State and Territorial Health Officers
AACC	Association for the Aid of Crippled Children
CES	Committee on Economic Security
CSHCN	Children with Special Health Care Needs
CCS	Crippled Children's Services
EMIC	Emergency Maternity and Infancy Care
FSA	Federal Security Agency
FOE	Federal Office of Education
HEARTH	Home Economics Archive: Research, Tradition and History
ISCC	International Society for Crippled Children
MCH	Maternal and Child Health
NARA	National Archives and Records Administration

NCSW	National Conference of Social Work
NOPHN	National Organization of Public Health Nurses
NTA	National Tuberculosis Association
NYCACIPC	New York Committee on After Care of Infantile Paralysis Cases
OSCC	Ohio Society for Crippled Children
RAC	Rockefeller Archive Center
STA	Sheppard-Towner Act
SSA	Social Security Act
SWHA	Social Welfare History Archives
SCAA	State Charities Aid Association
TB	Tuberculosis
UAB	University of Alabama at Birmingham
USCB	United States Children's Bureau
USPHS	United States Public Health Service

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I visited numerous archives and libraries to complete this research including the Alabama Department of Archives and History in Montgomery, AL; the Amelia Gayle Gorgas Library at the University of Alabama; the Franklin D. Roosevelt Presidential Library in Hyde Park, New York; the Lister Hill Library of the Health Sciences at the University of Alabama at Birmingham; the Mervyn H. Sterne Library at the University of Alabama at Birmingham; the National Archives and Record Administration in College Park, Maryland; Rockefeller Archives Center in Sleepy Hollow, New York; and the Social Welfare History Archives at the University of Minnesota. This dissertation greatly benefited from the help of the numerous archivist and librarians at these institutions who patiently answered my questions, located countless documents, and offered their insight and advice. My research trips to several of the archives would not have been possible without the financial assistance of the Clarke Chambers Travel Fellowship at the Social Welfare History Archives, the Grant-in-Aid program at the Rockefeller Archive Center, the Graduate Student Association Research and Travel Fund at the University of Alabama, the School of Social Work at the University of Alabama, and the University of Alabama Graduate School. I am also grateful to the Columbia University Oral History Research Office in New York City, New York; the Rockefeller Archive Center; the Schlesinger Library at Harvard University; and the Social Welfare History Archives for permission to quote from their collections.

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## CHAPTER 1

### INTRODUCTION

#### Description and Research Questions

With the passage of the Social Security Act (SSA) in 1935, the federal government established a new program to meet the social and medical needs of crippled children.<sup>1</sup> Together with the Maternal and Child Health Program (MCH), Crippled Children's Services (CCS) was a new departure in federal services. Unlike previous federal child health programs, MCH and CCS, established by Title V of the SSA, provided federal funds to states for medical and preventive care for mothers and children (MCH) and children with crippling and physically disabling conditions (CCS).<sup>2</sup> For some states, the CCS program meant an expansion of current services and new patterns of service provision, while other states were able to develop entirely new services. Novel and innovative practices for the time were introduced to these state programs such as preventive care and interdisciplinary services.<sup>3</sup>

Title V also marked the initiation of federal medical care for children. The United States Children's Bureau (USCB), the federal agency responsible for administering the program, had never before organized direct medical care for children, especially care

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<sup>1</sup> The term "crippled children" was the common term used during this time period to refer to Children with Special Health Care Needs (CSHCN).

<sup>2</sup> Bradbury, Dorothy. *Four Decades of Action for Children: A Short History of the Children's Bureau*. Washington, DC: US Government Printing Office, 1956; Wallace, Helen M., and William M. Schmidt. "The Development of Health Services for Mother and Children in the United States." In *Maternal and Child Health Practices*, 3-45. Oakland, CA: Third Party Publishing Company, 1988.

<sup>3</sup> Wallace and Schmidt, "The Development of Health Services for Mothers and Children," 14.

involving complex social and medical needs from multiple providers such as physicians, surgeons, nurses, social workers, and physical therapists. With a humble budget of \$2.8 million dollars in 1936 (\$200 million in 2008 dollars), the federal CCS program developed over the next seventy years into a stable and diverse child health program, known today as Children with Special Health Care Needs (CSHCN). This program serves over 1.8 million children each year with an annual budget of \$5 billion in state and federal appropriations.<sup>4</sup>

This study investigates the reasons why this unique federal child health program was established during the 1930s and how it evolved during its early years. Organized efforts to help crippled children in the United States began in the late nineteenth century, but the period from the 1920s to the start of World War II marked a distinctive transition from progressive era reform efforts to professional public health and social welfare programs. The CCS program offers a typical example of this transition at the federal level.

Many social, political, and economic factors contributed to the development and subsequent growth of federal services for crippled children. Local and state-level private charities and institutions provided a unique advocacy and service provision effort that pushed the plight of crippled children onto the national reform agenda of the 1930s. Progressive era reformers working at the national level provided essential support, advocacy, and oversight to the overall creation and growth of the federal CCS within the

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<sup>4</sup> Maternal and Child Health Bureau, *Celebrating 65 years of Title V: The Maternal and Child Health Program, 1935-2000*, Rockville, MD: US Department of Health and Human Services, 2001; Maternal and Child Health Bureau, "Federal and Federal-State Title V Block Grant Partnership Budget Earmarked for Children with Special Health Care Needs," <https://perfdata.hrsa.gov/mchb/mchreports/Search/financial/finsch04.asp>; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1774 to Present." Measuring Worth, <http://www.measuringworth.com/worthmeasures.html>.

larger framework of the SSA. Medical and health care professionals promoted the expansion of medical and social treatments for crippled children. Further, the role of the federal government expanded dramatically during the 1930s, creating new opportunities for federal-state partnerships in the areas of health and welfare. These factors -- the role of reformers and professional groups, the role of state-level private charities and children's institutions, and the increasing authority of the federal government in social programs -- provide a framework to address the following research questions:

1. What led to the creation of the federal CCS program in 1935?;
2. What influences played a decisive role in the development of the CCS program during its early years?

#### Development of Federal Crippled Children Services

When Congress enacted the SSA in 1935, the best available data estimated that there were over 300,000 children in the United States with crippling conditions.<sup>5</sup> Most states provided some form of state-level appropriations for crippled children's services; however, there was no consistency among state services and appropriations were often small.<sup>6</sup> The USCB estimated that \$5.5 million dollars (\$493 million in 2008 dollars) was spent annually in 1934 on care for crippled children, but that \$8 to \$9 million (\$628 to \$717 million in 2008 dollars) was really needed.<sup>7</sup> The federal government did support preventive maternal and child health educational services under the provisions of the Sheppard-Towner Act (STA) for the protection of Maternity and Infancy between 1921

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<sup>5</sup> White House Conference on Child Health and Protection. *The Handicapped Child: Report of the Committee on Physically and Mentally Handicapped*, New York, NY: The Century Company, 1933.

<sup>6</sup> Grotberg, Edith Henderson. *200 Years of Children*. Washington, DC: US Government Printing Office, 1977.

<sup>7</sup> Committee on Economic Security. *Social Security in America: The Factual Background of the Social Security Act as Summarized from Staff Reports to the Committee on Economic Security*, Washington, DC: Government Printing Office, 1937; Officer and Williamson, "Six Ways to Compute".

and 1929. However, no federal programs or funding sources existed to support services for crippled children before 1935.

Starting in the late nineteenth century, local communities and state governments took responsibility for the treatment and care of crippled children in the United States. Social reformers, health care professionals, and private citizens worked together to create treatment programs in large municipalities. Subsequent reformers promoted the expansion of services to all children in their states. These programs developed according to local needs and available resources, and thus resulted in a wide variety of service patterns throughout the United States. Examples of these services included institutional care in hospitals and convalescent homes, outpatient and after care services through clinics and home nursing agencies, and educational programs. By the late 1920s, social reformers and public officials recognized that the future improvement of services for crippled children required a national program to coordinate and support state-level efforts. The development of the SSA in the mid-1930s offered child health advocates a unique opportunity to establish a national program for crippled children.

Once the SSA was signed into law, state governments quickly applied for funding to develop or expand their crippled children's services. By 1936, the USCB had approved thirty-eight state plans.<sup>8</sup> Recognizing that most of the SSA's health and welfare programs were new to the federal government, USCB appointed technical advisory committees to guide and help develop the programs. Members of the American Association of Medical Social Workers (AAMSW) and the Association for State and Territorial Health Officers (ASTHO) participated on the advisory committee for crippled

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<sup>8</sup> Eliot, Martha M. "The Social Security Act and Crippled Children." *The Crippled Child* 14, no. 3 (1936): 35-37.

children and provided extensive technical assistance to the Bureau in the development of CCS policies and programmatic guidelines.<sup>9</sup>

Federal appropriations for the CCS program increased steadily during its first decade, from \$2.8 million in 1936 to \$3.8 million in 1941 (\$200 million and \$187 million in 2008 dollars, respectively).<sup>10</sup> Within a few years, all states and eligible territories, including the District of Columbia, were participating in the program. As dictated by the SSA, state and territorial CCS programs improved the quantity and quality of medical and social services for crippled children from services provided prior to 1935. New services were added in the late 1930s to cover children with non-orthopedic conditions such as rheumatic heart fever and visual and hearing impairments.<sup>11</sup> By 1941, most state-level crippled children's programs were well established within their respective state governments. However, the United States entry into World War II saw the rapid deployment of key medical and social work professionals from domestic programs into the military and other essential war-effort positions. While most state-level CCS programs experienced a loss of personnel and declines in appropriations during the war, they continued to provide services to crippled children, but not to the same level as the previous five years. With this impact on the federal CCS program, the entry of the United States into World War II serves as an end for this study.

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<sup>9</sup> Eliot, Martha M. "Foreword." In *Medical Social Services for Children in the Maternal and Child Health and Crippled Children's Programs*, iii-v. Washington, DC: US Government Printing Office, 1953, iv; Stites, Mary A. *History of the American Association of Medical Social Workers*. Washington, DC: American Association of Medical Social Workers, 1955.

<sup>10</sup> Maternal and Child Health Bureau. *Celebrating 65 years of Title V*, 24.

<sup>11</sup> Wallace and Schmidt, "The Development of Health Services for Mother and Children," 14.

## Significance of Research

In 2001, Vince Hutchins, former director of the Maternal and Child Health Bureau (the federal agency responsible for administering Title V programs at the time), summed up the importance of a historical perspective for children's health policy when he wrote that: "the Maternal and Child Health/Title V program and its many partners need to review their past history and approaches, modify their approaches for the new era, reaffirm their purpose and provide the leadership required."<sup>12</sup> His statement suggests three reasons why this study is important.

First, it is essential to understand the history of federal children's health policy development in the United States. As many present-day children's health programs were created during the first half of the twentieth century, a historical review of their development can provide insight into current programs and policies, and possibly provide guidance for future policies.<sup>13</sup> Also, the link between early child health programs and social welfare in the United States is an understudied aspect of social welfare history. Social work historians have focused more attention on the SSA's child welfare programs such as Aid to Dependent Children (ADC) and the Title V child welfare program rather than child health programs.<sup>14</sup> This study will place the development of federal child health policies in historical perspective to help social work and public health practitioners, pediatricians, and students understand the origins of today's agencies and

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<sup>12</sup> Hutchins, Vince L. *Maternal and Child Health at the Millennium: Looking Back, Moving Forward*. Washington, DC: National Center for Education in Maternal and Child Health, 2001, v.

<sup>13</sup> Leighninger, Leslie H. "Historiography." In *Encyclopedia of Social Work*, edited by Richard L. Edwards, 1252-1256. 19th ed. Washington DC: National Association of Social Workers, 1995; Stuart, Paul. "Historical Research." In *Social Work Research and Evaluation*, edited by Richard M. Grinnell, 442-457. Itasca, IL: F.E. Peacock Publishers, Inc, 1997.

<sup>14</sup> Hanlan, Archie. "From Social Reform to Social Security: The Separation of ADC and Child Welfare." *Child Welfare* 45, no. 9 (1966): 493-500; Trattner, Walter I. *From Poor Law to Welfare State: A History of Social Welfare in America*. New York, NY: The Free Press, 1999.

policies, and their relevance to program policy and development in the twenty-first century. Further, the study of child health programs developed during the 1930s will help historians understand the New Deal and its impact on American society.

Second, practice models and policies from early child health programs will help guide current programs. Chambers suggested that historical reviews can recover practices and programs “lost” to current social work practitioners.<sup>15</sup> Current child health leaders, including social workers, are concerned about the narrow medical and biological approaches that now dominate and shape policy and services.<sup>16</sup> Child health programs in the early twentieth century utilized social and environmental interventions in addition to medical treatments. For example, the federal CCS program required states to develop case finding, screening and diagnostic, and after care services to supplement orthopedic treatments. Today, some child health advocates have called for increased application of social and environmental interventions in child health practice, similar to the 1930s.<sup>17</sup>

Third, this study will address important professional development issues pertinent to the professions of social work and public health. History can provide an understanding of how legislation and policy development affects a profession, providing a deeper understanding of the work and practice of a profession.<sup>18</sup> An exploration of the federal CCS program can provide an understanding of the positive and negative influences of

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<sup>15</sup> Chambers, Clarke. “The Discipline of History in a Social Welfare Curriculum.” *Journal of Education for Social Work* 9, no. 1 (1973): 11-22.

<sup>16</sup> Klerman, Lorraine V. “Promoting the Well-Being of Children: The Need to Broaden Our Vision—The 1996 Martha May Eliot Award Lecture.” *Maternal and Child Health Journal* 1, no. 1 (1997): 53-59; Lindenmeyer, Kriste. *A Right to Childhood: The US Children's Bureau and Child Welfare, 1912-1946*. Urbana, IL: University of Illinois Press, 1997; Wise, Paul H. “Framework as Metaphor: The Promise and Peril of MCH Life-Course Perspectives.” *Maternal and Child Health Journal* 7, no. 3 (2003): 151-156.

<sup>17</sup> Klerman, “Promoting the Well-Being of Children,” 55; Wise, “Framework as Metaphor,” 154.

<sup>18</sup> Fisher, Robert. ““Speaking for the Contribution of History”: Context and the Origins of the Social Welfare History Group.” *Social Service Review* 73, no. 2 (1999): 191-217; Scally, Gabriel, and Justine Womack. “The Importance of the Past in Public Health.” *Journal of Epidemiology and Community Health* 58, no. 9 (2004): 751-755.

public health and medicine on the social work profession, especially related to medical social work. The recent National Association of Social Workers' reinvestment initiative highlighted the growing need to recruit and retain social workers in the profession.<sup>19</sup> Historical research can be a tool to develop leadership skills and professional commitment among public health social workers and other public health practitioners.<sup>20</sup> The development of the federal CCS program can offer insights into the advancement of medical social work and the practice of public health during the 1930s and 1940s.

### Discussion of Chapters

Child-saving work on behalf of crippled children was popular during the Progressive Era (1890s-1920s). Chapter Two describes a variety of treatment and advocacy programs for crippled children at the local and state levels prior to the passage of the SSA in 1935. Treatment programs included children's hospitals, convalescent homes, outpatient clinics, and school-based educational programs. Advocacy efforts included work by voluntary health organizations, private charities, and fraternal orders such as the Shriners or Rotary Clubs. Service providers and advocates associated with these programs became a powerful voice for crippled children, and actively contributed to national reforms for child health programs. Their programs and policies informed the design and service patterns of the federal CCS program.

Chapter Three examines the development of a national reform agenda based on state and local efforts for crippled children during the Progressive Era. This chapter uses

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<sup>19</sup> National Association of Social Workers, "Social Work Reinvestment Initiative," *Social Work Reinvestment Initiative*, <http://www.socialworkreinvestment.org/>; Whitaker, Tracey, Toby Weismiller, and Elizabeth J. Clark. *Assuring the Sufficiency of a Frontline Workforce: A National Study of Licensed Social Workers*. Washington, DC: National Association of Social Workers, 2006.

<sup>20</sup> Alexander, Greg R. "Our Legacy for Leadership in MCH." *Maternal and Child Health Journal* 7, no. 3 (2003): 145-150.

information from the proceedings of national conferences such as the White House Conferences for Children and the National Conference of Social Work (NCSW) to illustrate the growing national interest in programs for crippled children. Many factors influenced this transition including the growth of state-level services for crippled children, the expansion of federally funded public health programs in the 1920s, and the increase in private volunteer activity on behalf of crippled children.<sup>21</sup>

Chapter Four chronicles the actual development of the CCS federal legislation and its contribution to the expansion of the federal government during the New Deal. Leaders from the USCB drafted the initial reports that ultimately became Title V and evidence suggests that the program for crippled children was a calculated attempt by the Children's Bureau to introduce federal medical care for all Americans. Some factors that contributed to the successful inclusion of the CCS program in the SSA include the strong support from local and state-level programs for crippled children, the lack of opposition from the American Medical Association (AMA), and the ambitions of national child advocates to create a federal health care program for all children.

Chapter Five explores the implementation of the federal CCS program from its initiation in 1936 to 1941, when the United States entered World War II. While the federal CCS program did not stop operating during the war, key personnel such as physicians and nurses were drafted or volunteered for the war effort, leaving state CCS programs understaffed. The federal CCS program grew rapidly in size and funding during its early years, and amendments to the Social Security Act in 1939 promoted an

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<sup>21</sup> Solenberger, Edith Reeves. "Crippled Children with Special Reference to Ten State Programs," 1928, Letter A-1, Part 3, Reel 71, The Records of the Children's Bureau, 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

expansion of crippling conditions treated by state and territorial CCS programs. Federal administrators also developed new standards of care for hospitals and convalescent homes for crippled children as well as minimal qualifications and training programs for professional personnel in state CCS programs.

Chapter Six discusses the major findings of the study and their implications for the fields of social work, public health, and MCH. Social welfare and public health policy for crippled children was transformed between the Progressive Era and World War II. Initially a grassroots advocacy campaign, by the late 1930s, the goal was professional health care for all children. Leaders within the USCB expanded the role of child health programs in the United States, taking an important first step in securing the right to health care for all American children. The story of the federal CCS program also provides an important example of the inquiry-advocacy model developed and promoted by the USCB during its early years.<sup>22</sup> The USCB designed and implemented studies of the problems of childhood, which subsequently provided the basis for endorsing state and federal legislation and policy changes to improve the health and well-being of children and their families.<sup>23</sup> Finally, the CCS program provides significant insight into the development of public health social work as a unique specialty within the social work and public health professions. To meet programmatic demands, social workers employed in state-level CCS programs in the late 1930s were forced to develop new practice skills such as

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<sup>22</sup> Bierman, Jessie M. "Advocacy and Inquiry: Their Roles in Development of Health Services for Mothers and Children." *American Journal of Public Health* 56, no. 5 (1966): 720-725.

<sup>23</sup> Parker, Jacqueline K., and Edward M. Carpenter. "Julia Lathrop and the Children's Bureau: The Emergence of an Institution." *The Social Service Review* 55, no. 1 (1981): 60-77.

consultation and coordination, thus expanding professional boundaries and contributing to the development of an interdisciplinary social work specialty.<sup>24</sup>

The research methods and sources used in this study are described in Appendix A. The checklist used to assess primary source documents for this research can be found in Appendix B. This study focuses on the growth of federal institutions and policies related to crippled children in the United States from the 1890s to the early 1940s. While attention is given to state-level expansion and private charity work, it is not the goal of this study to detail efforts by state governments and non-governmental groups for crippled children after the SSA. Similarly, this study does not attempt to chronicle the personal experiences of crippled children and their families during this time. This research will describe the development of federal programs for crippled children as an example of the transition from Progressive Era reform to a professional public health and social welfare program.

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<sup>24</sup> Bucher, Rue, and Anselm Strauss. "Professions in Process." *The American Journal of Sociology* 66, no. 4 (1961): 325-334.

## CHAPTER 2

### EFFORTS FOR CRIPPLED CHILDREN PRIOR TO THE SOCIAL SECURITY ACT, 1890 – 1934

"It is impossible to avoid the feeling that no more successful subject could be presented to the public than that of crippled children."

*From the Minutes of the Rockefeller Foundation Board of Directors Meeting, March 2, 1920<sup>1</sup>*

By the 1890s, social reformers and health care professionals in the United States embraced the mission of child saving. Reformers focused their attention on the hardships of childhood as a way to address the social ills of society. Their programs and policies sought to reduce or eliminate the problems of child labor, infant mortality, juvenile delinquency, and child abuse and neglect.<sup>2</sup> Child savers believed that crippled children were a worthy group of children in need of care and services because they suffered from painful and tragic medical conditions through no fault of their own. Charity organizations and other groups responsible for the care of crippled children often described the conditions of children under their care in reports:

...little Martin, nine years old, who was born without any bone in his legs

below the knee. When he was first referred to us by a neighborhood worker he

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<sup>1</sup> "Minutes of the Rockefeller Board of Directors Meeting, March 2, 1920," Folder 282, Box 25, Series 200, Record Group 1.1, Rockefeller Foundation Archives, Rockefeller Archive Center, Sleepy Hollow, New York (hereafter designated RAC).

<sup>2</sup> Ashby, Leroy. *Saving the Waifs: Reformers and Dependent Children, 1890-1917*. Philadelphia, PA: Temple University Press, 1984.

was unable to stand or to use his lower limbs in any way, and could only crawl about on the floor like a baby...<sup>3</sup>

This case is a dear little girl paralyzed in both legs as a result of poliomyelitis. She has not been able to stand upright, so that her method of locomotion is by crawling crab-wise on the floor at home...<sup>4</sup>

There are many patients who flounder aimlessly about clinics for weeks and months endeavoring to gain health, but who more often, because of lack of convalescent care, become one of the many 'half-cured'.<sup>5</sup>

Reformers condemned the lack of services and opportunities for these children. They believed that crippled children or "little unfortunates" should have access to medical care, the chance to walk, and the opportunity to be healthy and happy like children without physical disabilities. Crippled children often went without treatment because their families could not afford treatment or because services were not available in their city or county. From the 1890s to the 1930s, local and state governments, private charities, and fraternal organization such as the Shriners and Rotary Clubs developed numerous programs and services for crippled children. These programs resulted in a patchwork of treatment and service programs across the nation that included children's hospitals, convalescent homes, outpatient services, and school-based educational programs. These

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<sup>3</sup> Association for the Aid of Crippled Children, "Annual Report, 1918-1919", 1919, 7, Reel 32, *Annual Reports, 1909-1996*, Foundation for Child Development, Microfilm Collection, RAC.

<sup>4</sup> Hare, Helen. *A Study of Handicapped Children: Based on One Hundred and Fifty Crippled Children Referred to the Social Service Department of Indiana University*. Bloomington, IN: Indiana University, 1919, 20.

<sup>5</sup> Abt, Henry Edward. *The Care, Cure, and Education of the Crippled Child*. Elyria, OH: The International Society for Crippled Children, 1924, 46.

programs not only provided direct services to crippled children, but also informed the creation and development of the future federal Crippled Children's Services (CCS) program.

### Who were crippled children?

Similar to other child health problems of the day such as infant mortality, infectious disease, and malnutrition, little epidemiological research had been done on the causes of crippling conditions among children at the start of the twentieth century.<sup>6</sup> The federal government had yet to collect national data on the number of crippled children in the United States, although several states and cities such as Massachusetts (1905), New York City (1920) and Cleveland, Ohio (1916) collected data on crippled children living in their localities.<sup>7</sup> To meet the demand for accurate data, some federal agencies and national organizations also conducted investigations on topics related to the needs of crippled children such as education, institutional care, and state-level programs for crippled children. Findings from these reports provide insight into the demographics of crippled children in the early twentieth century and what was being done to help them.

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<sup>6</sup> Meckel, Richard A. "Levels and Trends of Death and Disease in Childhood, 1620 to the Present." In *Children and Youth in Sickness and in Health: A Historical Handbook and Guide*, edited by Janet Lynne Golden, Richard A. Meckel, and Heather Munro Prescott, 3-24. Westport, CT: Greenwood Press, 2004.

<sup>7</sup> Massachusetts Bureau of Statistics of Labor. *Census of the Commonwealth of Massachusetts, 1905: Occupations and Defective Social and Physical Condition*. Vol. 2. 2 vols. Boston, MA: Wright & Potter Printing Company, 1910; Wright, Henry Collier. *Survey of Cripples in New York City*. New York, NY: New York Committee on After Care of Infantile Paralysis Cases, 1920; Wright, Lucy, Amy M. Hamburger, and Welfare Federation of Cleveland, Committee on Cripples. *Education and Occupation of Cripples, Juveniles and Adults*. New York, NY: Red Cross Institute for Crippled and Disabled Men, 1918.

### *Defining and Counting Crippled Children*

Early on, the term “crippled” commonly referred to children or adults with physical deformities due to disease, birth defects, or accidents.<sup>8</sup> Other terms included “deformed”, “physically handicapped,” or having an “orthopedic condition.” Reformers and professionals considered crippled children different from other physically handicapped children (blind, deaf, or intellectually disabled) because with medical treatment and proper education, crippled children could be cured.<sup>9</sup> Table 1 provides a list of common definitions used to describe crippled children before 1935. As can be seen, these definitions developed in complexity and length over time. Early definitions focused primarily on medical symptoms related to bones and muscles while later definitions included descriptors of age and the loss or limitation of activity.

Without a national survey on the prevalence of crippled children or adults in the United States, experts relied on data from the regional and local surveys. Table 2 includes data from ten different regional and city-wide surveys of crippled children conducted between 1905 and 1931. Prevalence rates for crippled children ranged from 1.3 per 1,000 children in Cleveland, Ohio in 1916 to 9.0 per 1,000 in Tuscola County, Michigan in 1931.<sup>10</sup> Regional differences provided a convenient substitute for explanation of the large discrepancies in prevalence rates. The lack of a standardized definition for crippling conditions made it difficult for reformers to determine the number of crippled children in

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<sup>8</sup>Seham, Grete E. *A Scientific Survey of the Crippled Children of Hennepin County, Minnesota*. Minneapolis, MN: The Hennepin County Council on Crippled Children, 1929; White House Conference on Child Health and Protection. *The Handicapped Child: Report of the Committee on Physically and Mentally Handicapped*. New York, NY: The Century Company, 1933.

<sup>9</sup>Hare, *A Study of Handicapped Children*, 7.

<sup>10</sup>Upson, Lent Dayton, Opal V. Matson, and Harold Hunter Emmons. *Crippled Children in Michigan: A Study of Their Care, Maintenance and Education*. Detroit, MI: Courier-Berghoff, Inc, 1931; Wright, Hamburger, and Welfare Federation of Cleveland, *Education and Occupation of Cripples*, 13.

Table 1. Definitions of Crippled Children in the United States, 1905-1930

Author & Date of Report	Definition (with page number)
Wright & Hamburger (1918)	“...who are handicapped because they lack the normal use of skeleton or skeletal muscles.”
Wright (1920)	“Those handicapped by some limited or distorted use of muscle, joints of skeletal members.”
Abt (1924)	“...one, who by reason of congenital or acquired defects of development, disease or trauma, is deficient in the use of its body or limbs.”
Solenberger (1928)	“...one whose activity is, or due to a progressive disease may become, so far restricted by loss, defect or deformity of bones or muscle, as to reduce his normal capacity for education or for self-support.”
White House Conference on Child Health and Protection (1930)	“... is one, under twenty-one years of age, who by reason of congenital or acquired defects of development, disease or wound, is, or may be reasonably expected to become, deficient in the use of his body or limbs (an orthopedic cripple) including hare lip, cleft palate, and some other handicaps yielding plastic surgery, and excluding physical difficulties, wholly of sight, hearing or speech, and those affecting the heart primarily, and also excluding serious mental or moral abnormalities unless found in conjunction with orthopedic defects.”

*Sources:* Abt, *Care, Cure and Education*, 11; Solenberger, *Crippled Children with Special Reference*, 2; White House Conference on Child Health and Protection, *The Handicapped Child*, 119; Wright, Hamburger, and Welfare Federation of Cleveland, *Education and Occupation of Cripples*, 13; Wright, *Survey of Cripples in New York City*, 33.

the United States. Some surveys excluded children with rickets because their condition was due to poor nutrition, not disease or accidents.<sup>11</sup> Further, some studies counted the children using reports from social service agencies or the testimony of neighbors or janitors of large apartment buildings rather than direct, door-to-door surveys.<sup>12</sup> Most likely, the resulting data underrepresented the number of physically handicapped children in certain regions and overrepresented the number in other areas.

To determine the national prevalence of crippled children, experts used rates from local or regional investigations to calculate weighted estimates based on the 1920 and 1930 United States Census numbers. Table 3 shows data from three reports using this method. The International Society for Crippled Children (ISCC), a non-profit advocacy and research organization established in 1921, reported in 1924 that there were over 250,000 crippled children (2.5 per 1,000) in the United States.<sup>13</sup> Four years later, the United States Children's Bureau (USCB) estimated that 250,000 to 300,000 crippled children (2.5 to 3.0 per 1,000) lived in the United States.<sup>14</sup> The most comprehensive estimates came from the 1930 White House Conference on Child Health Protection. Members of the Conference's Committee on Physically and Mentally Handicapped pulled data from dozens of reports on crippled children, estimating that 3.0 per 1,000 children under the age of eighteen in the general population suffered from a crippling condition. Using this ratio, the Committee calculated that there were 368,325 crippled children in the United States, based on the 1930 Census general child population data.<sup>15</sup>

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<sup>11</sup> Abt, *The Care, Cure, and Education*, 12; Kansas Crippled Children's Temporary Commission. *Report of the Kansas State Crippled Children's Temporary Commission*. Topeka, KS: State of Kansas, 1931, 13.

<sup>12</sup>Wright, *Survey of Cripples in New York City*, 5; Wright to McLane, November 21, 1919, Folder 282, Box 25, Series 200, Record Group 1.1, Rockefeller Foundation Archives, RAC.

<sup>13</sup>Abt, *Care, Cure and Education*, 69.

<sup>14</sup>Solenberger, *Crippled Children with Special Reference*, 2.

<sup>15</sup>White House Conference on Child Health and Protection, *The Handicapped Child*, 134.

Table 2. City-wide and Regional Surveys of Crippled Children in the United States, 1905-1930

Place	Date	Total Number of Crippled Children Identified by Survey	Rate of Crippled Children in City or Region
Massachusetts	1905	382	2.8 per 1,000
New York City	1914	208	5.3 per 1,000
Cleveland, OH	1916	936	1.3 per 1,000
New York City	1920	36,000	3.6 per 1,000
Chicago, IL	1925	4,609	1.6 per 1,000
New York State	1925	6,579	1.4 per 1,000
Hennepin County, MN	1928	904	2.1 per 1,000
New Jersey	1929	10,109	7.2 per 1,000
Tuscola County, MI	1931	302	9.0 per 1,000
Kansas	1931	3303	5.8 per 1,000

*Sources:* Massachusetts Bureau of Statistics of Labor, *Census of the Commonwealth of Massachusetts, 1905*, 341; Wright, *Survey of Cripples in New York City*, 10; Wright, Hamburger, and Welfare Federation of Cleveland. *Education and Occupation of Cripples*, 22; Stevenson, *Crippled Children in Chicago: May-December, 1924*, 14; Seham, *A Scientific Survey*, 15; State of New York, *Report of the New York State Commission for Survey of Crippled Children*, 18-19; Temporary Commission for Inquiry Relating to the Distribution and Condition of Crippled Children, *Report of the New Jersey State Temporary Commission for Inquiry Relating*, 8; Upson, Matson, and Emmons, *Crippled Children in Michigan*, 33; Kansas Crippled Children's Commission, *Report of the Kansas State*, 13.

While the Committee recognized that these numbers were only estimates and did not reflect the actual number of crippled children, these estimates would be the most frequently quoted until the USCB began collecting national data in the late 1930s as part of the federal CCS program. In 1942, the Bureau reported that there were over 328,000 crippled children under the age of 21 in the United States, or about 6.7 per 1,000.<sup>16</sup> These calculations were based on the number of crippled children registered with state CCS programs and the 1940 Census data for the general child population.

In the mid-1920s, the ISCC petitioned the United States Census Bureau to include crippled children in its annual census, as the Bureau had done in its 1910 enumeration of individuals who were blind, deaf, or intellectually disabled.<sup>17</sup> The Census Bureau expressed no interest in counting the number of crippled children, citing the time and expense that would be required. Undeterred, ISCC executive secretary Harry Howett enlisted the assistance of the USCB. Howett also served as executive director for the Ohio Society for Crippled Children, an affiliate of the ISCC, and was active in the development of services for crippled children in Ohio during the 1920s.<sup>18</sup> At the time, the Children's Bureau had a strong interest in child health, but had done little work on behalf of crippled children. For many years, the Children's Bureau referred requests for information on crippled children to the ISCC because the Bureau lacked its own studies and published information on crippled children. In 1925, USCB chief Grace Abbott commissioned Edith Reeves Solenberger to complete a modest study to investigate the

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<sup>16</sup> Yerushalmy to Daily and Van Horn, "Quarterly Summary of Crippled Children on State Registers, December 21, 1941," April 11, 1942, 2, Folder 14-2-7(0), Box 290, Records of the Children's Bureau, RG 102, National Archives Record Administration, College Park, MD (hereafter designated NARA).

<sup>17</sup> United States Census Bureau. *Benevolent Institutions, 1910*. Washington, DC: US Government Printing Office, 1913.

<sup>18</sup> "Rotary and Care for Crippled Children," *Rotary Global History Web Site*, April 29, 2009. <http://www.rotaryfirst100.org/foundation/grants/easterseals/>.

Table 3. National Prevalence Data of Crippled Children in the United States, 1924-1933

Organization	Date	Total Number of Crippled Children	Rate of Crippled Children in US
International Society for Crippled Children	1924	264,276*	2.5 per 1,000
United States Children's Bureau	1928	250,000 -300,000*	2.5 – 3.0 per 1,000
White House Conference on Child Health and Protection	1930	368,000**	3.0 per 1,000
United States Children's Bureau, Division of Crippled Children	1941	328,223***	6.7 per 1,000

*Sources:* Abt, *Care, Cure and Education*, 69; Solenberger, *Crippled Children with Special Reference*, 134; White House Conference on Child Health and Protection, *The Handicapped Child*, 2; "Quarterly Summary of Crippled Children on State Registers, December 31, 1941," April 11, 1942, 2.

\*Based on 1920 Census Data.

\*\*Based on 1930 Census Data.

\*\*\*Based on 1940 Census Data.

types of services provided to crippled children by ten state-level agencies. Considered an expert on issues related to the needs of crippled children, Solenberger had completed earlier research on services for crippled children for the Russell Sage Foundation in 1914 and the Federal Office of Education (FOE) in 1918. Although the research took over three years to complete and the results were never published, the study provided information the USCB used in developing their recommendations for child health care programs to be included in Social Security Act (SSA).

The Children's Bureau noted that the inclusion of crippled children in a census count was problematic without a standardized definition of crippling handicaps. Further, it would be useful only if based on a house-to-house survey, not on the number of children in crippled children's institutions.<sup>19</sup> Katherine Lenroot, assistant chief of the Bureau, held meetings and corresponded with Dr. Frank Steuart, then Director of the Census Bureau, starting in September 1926, regarding the inclusion of crippled children in the 1930 census.<sup>20</sup> While Steuart expressed willingness to receive recommendations from the Children's Bureau and its partners, he was not inclined to include questions about crippled children on the Census questionnaire, believing questions about crippled children would make the questionnaire unmanageable. Over the next few years, the USCB and the ISCC continued to petition the Census Bureau, but the 1930 census did not enumerate crippled children.

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<sup>19</sup> Lenroot to Howett, August 10, 1926, Folder 7-5-5-0, Box 295, Records of the Children's Bureau, RG 102, NARA.

<sup>20</sup> Lenroot to Howett, September 14, 1926, Folder 7-5-5-0, Box 295, Records of the Children's Bureau, RG 102, NARA.

### *Causes and Treatment of Crippling Conditions among Children*

No single cause of crippling conditions among children was identified during the early twentieth century. The most common causes were infantile paralysis, tuberculosis, and rickets. Other causes included congenital deformities and accidents.

Infantile paralysis, or polio, remained one of the leading causes of handicapping conditions among children in the United States until the discovery of a vaccine in the 1950s. Polio accounted for deformities among 17% to 51% of all crippled children.<sup>21</sup> Most children afflicted with the polio virus recovered without lasting side effects, but some developed permanent muscle paralysis in their arms or legs. Conventional medical treatment included administering electric shocks to the paralyzed extremity, regular massage and passive motion exercises, the use of rigid braces or body casts, and surgery to lengthen or shorten limbs and tendons.<sup>22</sup>

Tuberculosis (TB), often referred to as surgical or bone TB in children, caused from 9% to 26% of the cases of physical deformities among children through the 1930s.<sup>23</sup> The TB bacterium settled into the bones or joints of children that weakened the areas and caused deformities. There was no cure for TB until the introduction of antibiotics in the 1940s. Available treatments at the time included rest and immobilization of the affected bone or joint to counteract possible deformities.<sup>24</sup>

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<sup>21</sup> Abt, *Care, Cure and Education*, 13; White House Conference on Child Health and Protection, *The Handicapped Child*, 134.

<sup>22</sup> Emerson, Haven. *A Monograph on the Epidemic of Poliomyelitis (infantile Paralysis) in New City in 1916: Based on the Official Reports of the Bureaus of the Department of Health*. New York, NY: New York City Department of Health, 1917.

<sup>23</sup> Abt, *Care, Cure and Education*, 13; White House Conference on Child Health and Protection, *The Handicapped Child*, 138.

<sup>24</sup> McBride, Earl D. *Crippled Children: Their Treatment and Orthopedic Nursing*. St. Louis, MO: The CV Mosby Company, 1937.

Many medical experts considered rickets, a softening of the bones due to poor nutrition, as another major cause of crippling. Because it was often excluded as a cause from surveys of crippled children, the small amount of data that existed on rickets showed it as cause of a crippling condition in up to 20% of crippled children.<sup>25</sup> Most surveys did not collect data on rickets because medical professionals did not consider it a disease or developmental condition, but a problem associated with living conditions and poverty.<sup>26</sup> The USCB, despite its lack of efforts for crippled children during the 1920s, did consider rickets a major child health problem and funded research to investigate treatment options. Dr. Martha May Eliot, a prominent pediatrician who became the assistant chief of the USCB in 1934, began a three-year community demonstration project in 1923 to study the use of cod liver oil and sunlight as a preventative measure of rickets in infants. Her research proved successful, and this treatment became standard medical advice for parents to prevent rickets in their children. Rates of the disease quickly dropped, and by 1940, rickets accounted for less than 4% of all cases of crippling conditions among children in United States.<sup>27</sup>

#### Types of Services and Programs for Crippled Children prior to 1935

As is the case for children with special health care needs (CSHCN) today, crippled children in the early twentieth century had complicated and diverse medical and social needs. They required orthopedic surgery and medical care to correct deformities, convalescent care or after care following surgery, social support and counseling to

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<sup>25</sup> Wright, *Survey of Cripples in New York City*, 47.

<sup>26</sup> Abt, *Care, Cure and Education*, 12; Reeves, Edith G. *Care and Education of Crippled Children in the United States*. New York, NY: Survey Associates, 1914, 20.

<sup>27</sup> Yerushalmy to Van Horn, November 22, 1941, Folder 14-2-7(0), Box 290, Records of the Children's Bureau, RG 102, NARA.

understand feelings associated with their disability, educational and vocational services, and financial and transportation assistance.<sup>28</sup> Different types of services developed to address these needs including case finding, expert medical diagnosis, medical and orthopedic treatment and surgery, convalescent care, custodial or foster care, educational services, and vocational rehabilitation training. During the late nineteenth century, institutional settings such as hospitals and convalescent homes provided most of the care for crippled children. In-home care developed partly to meet the needs of non-institutionalized children and partly to address the increasing demand for and cost of services for crippled children. Nationally, the cost of institutional treatment for a crippled child in 1914 ranged from \$153 to \$977 per year (\$19,400 to \$124,000 in 2008 dollars), with an average cost of \$406 (\$51,500 in 2008 dollars).<sup>29</sup> Private citizens and organizations developed services to care for crippled children, but over time, several state governments coordinated and financially supported the growing services through legislation and the establishment of special commissions. Despite the diverse nature of services for crippled children across the United States, programs typically developed to address local needs and were responsive to the changing needs of crippled children and their communities.<sup>30</sup>

### *Institutional Care*

Institutional or residential care was considered the best treatment for crippled children for at the turn of the century. Experts believed superior medical care could be

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<sup>28</sup> Abt, *Care, Cure and Education*, 37-52; Reeves, *Care and Education of Crippled Children*, 22-27; White House Conference on Child Health and Protection, *The Handicapped Child*, 139.

<sup>29</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" Reeves, *Care and Education of Crippled Children*, 121-122.

<sup>30</sup> McMurtrie, Douglas C. "The Care of Crippled Children in the United States." *The Journal of Bone and Joint Surgery* 2, no. 4 (1912): 527-556.

provided in residential settings where medical professionals could provide constant care without interference from uninformed or poorly educated parents. This care also included supervision of the child's moral and social well-being. Experts believed that maintaining a positive attitude and confidence was as important as proper medical care because it would prevent feelings of dependency and helplessness.

In 1900, seventeen institutions for crippled children existed in the United States, and by 1930, there were 325 such facilities.<sup>31</sup> Table 4 shows the increase in facilities for crippled children from 1890 to 1930. Three main types of institutions developed for crippled children: hospitals, convalescent homes, and custodial facilities. Table 5 provides data on the number of facilities by types of institutions from 1914 to 1930. With the exception of crippled children's hospitals, all types of facilities increased in numbers in the United States from 1890 to 1930. Two reasons could account for the lower number of crippled children's hospitals reported in 1930 compared to 1924. First, no standard definition existed during this time for what constituted a children's orthopedic hospital.<sup>32</sup> Second, some data suggested that while the number of hospital facilities for crippled children declined from 1924, the number of beds within these facilities increased. In 1924, 5,381 beds existed in crippled children's hospitals. Four years later, the *Journal of the American Medical Association* reported that there were 64 orthopedic hospitals for children in the United States with a total bed capacity of 5,731 beds.<sup>33</sup>

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<sup>31</sup> Hart, Hastings H. "Introduction." In *Care and Education of Crippled Children in the United States*, edited by Edith G. Reeves, 1-16. New York, NY: Survey Associates, 1914; White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

<sup>32</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

<sup>33</sup> "Hospital Service in the United States." *Journal of the American Medical Association* 92, no. 10 (1929): 1043-1129, 1045; White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

Table 4. Number of Institutions for Crippled Children in the United States, 1890-1930

Date	Number of Facilities for Crippled Children	Number of Beds
1890	5	N/A
1900	17	N/A
1914	52	2,913
1924	242	8,939
1930	325	11,321

*Sources:* Abt, *Care, Cure and Education*, 37-52; Reeves, *Care and Education of Crippled Children*, 6; White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

Table 5. Number of Institutions for Crippled Children by Type in the United States, 1914-1930

Type of Institution	1914	1924	1930
Hospitals	11	98	44
Convalescent Homes	22	45	73
Custodial Facilities	15	14	18
Sanatoria	3	45	150
General Children's Hospital	1	36	40
Total	52	242	325

*Source:* White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

*Hospitals.* Women reformers during the Progressive Era believed that children's medical needs were different from those of adults, and were inspired to design and create hospitals that treated only children.<sup>34</sup> Pediatricians and orthopedic surgeons quickly affiliated with these hospitals and, by the 1890s, most large cities in the United States had a Children's Hospital that provided orthopedic and surgical treatment to crippled children along with other pediatric services.<sup>35</sup> The first hospital to provide care for crippled children opened toward the end of the Civil War. In 1863, The Hospital for the Ruptured and Crippled in New York City admitted its first patient, a four-year old boy who suffered from paralysis in his legs.<sup>36</sup> A prominent orthopedic surgeon, Dr. James Knight, founded the hospital with the help of the New York Association for Improving the Condition of the Poor (NYAICP). The hospital financed its operations through charitable contributions and patient fees.<sup>37</sup> Dr. Knight and his staff provided orthopedic care and surgery for children and adults with all types of crippling conditions. Only children received indoor services (inpatient care) and both children and adults received outdoor services (outpatient treatment). Within its first year, the hospital cared for sixty-six patients including ten children who received long-term inpatient treatment. Ten years later, in 1874, the hospital served 299 children and 4,335 adults with crippling conditions.<sup>38</sup>

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<sup>34</sup> Hunt, Marion. "Women and Childsaving: St. Louis Children's Hospital, 1879-1979." *Missouri Historical Society* 36, no. 2 (1980): 65-79; Sloane, David. "'Not Designed Merely to Heal': Women reformers and the emergence of Children's Hospitals." *The Journal of the Gilded Age and Progressive Era* 4, no. 4 (2005): 331-354.

<sup>35</sup> Hunt, "Women and Childsaving," 71; Sloane, "'Not Designed Merely to Heal'," 344.

<sup>36</sup> Levine, David B. "Hospital for Special Surgery: Origin and Early History First Site 1863-1870: Hospital for the Ruptured and Crippled: first site: 1863-1870." *HSS Journal* 1, no. 1 (2005): 3-8.

<sup>37</sup> Levine, "Hospital for Special Surgery," 4; "New York Association for Improving the Condition of the Poor," Chambers, Clarke A., and Peter Romanofsky, eds. *Social Service Organizations*. 2 vols. Westport, CT: Greenwood Press, 1978, 623.

<sup>38</sup> "The Society for the Relief and of the Ruptured and Crippled." *The New York Times*. May 6, 1874.

The success of the Hospital for the Ruptured and Crippled encouraged the establishment of additional hospitals for crippled children in major urban centers throughout the United States. Medical experts and children's advocates argued that crippled children had unique needs that required specialized hospital care different from general hospital care. Typical inpatient features available at orthopedic hospitals for children included operating rooms, x-ray machines, plaster and brace equipment, orthopedic nursing care, classrooms and education services, and open air treatments for patients with TB.<sup>39</sup> These services were typically not available in general hospitals, especially in hospitals without pediatric wards. Additionally, crippled children often required extended recovery time following complicated surgery and orthopedic treatments. The average stay in Shriners' Crippled Children's Hospitals in 1924 was over three months (96 days) per child.<sup>40</sup> For financial reasons, most acute care hospitals could not accommodate such long hospital admissions.

During the early years of the twentieth century, more physicians and surgeons began specializing in orthopedics due, in part, to the increasing specialization of medicine following the Flexner Report of 1910.<sup>41</sup> The American Orthopaedic Association (AOA), the leading professional organization for orthopedic surgeons in the United States, also actively promoted the field through its publications and annual conferences.<sup>42</sup> The increase in orthopedic physicians contributed to an increase of institutions for crippled children. Orthopedic surgeons joined these facilities for training and employment. The

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<sup>39</sup> Abt, *Care, Cure and Education*, 47.

<sup>40</sup> Abt, *Care, Cure and Education*, 42.

<sup>41</sup> Starr, Paul. *The Social Transformation of American Medicine*. New York, NY: Basic Books, 1982, 118-122.

<sup>42</sup> Brown, Thornton. *The American Orthopaedic Association: A Centennial History*. Park Ridge, IL: The American Orthopaedic Association, 1987, 17-19.

AOA encouraged surgeons-in-training to obtain positions at orthopedic hospitals following general surgery residencies.<sup>43</sup> Leading orthopedic surgeons of the time, such as James McKnight, Virgil P. Gibney, and Arthur J. Gillette, were associated with orthopedic hospitals for children, and often played a leading role in the creation and management of these hospitals.<sup>44</sup> The prominent orthopedic medical journal of the day, AOA's *Journal of Bone and Joint Surgery*, frequently published articles about different facilities for crippled children along with technical articles on medical and surgical procedures.<sup>45</sup> The Journal published one of the first major articles on institutions and services for crippled children in 1912.<sup>46</sup>

As the number of crippled children's hospitals increased over time, their geographic distribution became problematic. Prior to 1905, no institutions existed west of the Mississippi river, and many states lacked facilities in rural areas.<sup>47</sup> In 1930, seven states had no institutions for crippled children within their border.<sup>48</sup> In addition, privately-run crippled children's hospitals in urban centers often experienced long waiting lists for services.<sup>49</sup> To meet the demand, state governments developed their own hospitals and homes for crippled children. The State of Minnesota established the first state-run hospital in 1897. Dr. Arthur J. Gillette, the hospital's first chief surgeon, worked with local advocates to petition the Minnesota state legislature for money and

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<sup>43</sup> Brown, *The American Orthopaedic Association*, 17-19; Jones, Robert. "Some Remarks on the Training and Activities of the Orthopaedic Surgeon." *The Journal of Bone and Joint Surgery* 8 no. 2 (1926): 247-256.

<sup>44</sup> Koop, Steven E. *We Hold This Treasure: The Story of Gillette Children's Hospital*. Afton, MN: Afton Historical Society Press, 1998; Hart, *Care and Education of Crippled Children*, 4.

<sup>45</sup> Cowell, H R. "A Brief History of the Journal of Bone and Joint Surgery." *Clinical Orthopaedics and Related Research* 374, no. 5 (2000): 136-144.

<sup>46</sup> McMurtrie, "The Care of Crippled Children in the United States."

<sup>47</sup> Hart, *Care and Education of Crippled Children*, 6.

<sup>48</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 160.

<sup>49</sup> Abt, *Care, Cure and Education*, 22.

land to establish the hospital. State hospitals for crippled children served two purposes. First, they provided surgical, medical, and convalescent care for all children within the state including children from rural areas. For example, the State of New York established its state hospital for crippled children in 1900 after recognizing that the many private orthopedic hospitals in New York City were not serving the rural areas of the state. Second, state hospitals provided care to indigent children. To be eligible for services at most publicly funded hospitals, crippled children and their families had to prove residency and indigent-care status.

Concerned about the potential misuse of these expensive medical services, several states including Ohio, New York and Michigan, created commitment laws for crippled children. These laws required a local judge to determine whether a crippled child was medically appropriate for services, if a parent or other guardian could not pay for the needed services, and if the family met state residency requirements. If a crippled child was committed, the State assumed temporary custody of the child for placement and treatment at a state hospital. In all, thirteen states had commitment laws for crippled children when the federal CCS program was established in 1935. For example, Ohio established commitments for crippled children in 1921, and on average, committed 327 children each year for publicly funded services, approximately 36% of all crippled children receiving services in the state.<sup>50</sup> In the early 1940s, the USCB actively began working with Ohio and other state governments to abolish the commitment laws. The Bureau argued that the court proceedings often delayed medical care for crippled children, interfered with the physicians' ability to provide appropriate medical and

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<sup>50</sup>Smith, Mabel. *The Crippled Child: The Ohio Plan for Care, Treatment and Education*. Columbus, OH: State of Ohio, Department of Public Welfare, Division of Charities Crippled Children's Bureau, 1931.

surgical treatment, and, most importantly to the Bureau, interfered with the administration of state-level crippled children's programs.<sup>51</sup> Nevertheless, removing the commitment laws proved difficult because they were integrated in the overall legislation for the crippled children's programs in most states. In 1942, Ohio, rather than eliminating its commitment laws, effectively weakened the court action requirements for crippled children by amending terminology used in the legislation.<sup>52</sup> By the end of World War II, states with commitment laws for crippled children had removed or rendered the laws ineffective.

*Convalescent homes.* Most hospitals could not provide long-term convalescent care to children needed for a complete and full recovery due to financial cost and bed demand. The average cost of a typical hospital stay for a crippled child in 1914 was \$570 (\$72,500 in 2008 dollars).<sup>53</sup> Convalescent homes for crippled children offered similar services as hospitals, but for longer periods of time and with less cost. The average cost of a typical stay at a convalescent home in 1914 was \$348 (\$44,200 in 2008 dollars).<sup>54</sup> Typical services provided in convalescent homes included medical treatment, nursing services, recreational activities, physical and occupational therapy, educational classrooms, and nutritional services. Because most convalescent facilities were located in rural or suburban areas, they offered the best living environment for recovery of TB or rickets, which included good food, fresh air, and sunshine.<sup>55</sup> Like other services for

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<sup>51</sup> "Recommendation for Revision of State Laws to Eliminate 'Court Action' as a Condition Precedent to Providing Services under State Crippled Children's Programs," Folder 14-2-0-3, Box 291, Records of the Children's Bureau, RG 102, NARA.

<sup>52</sup> Ruth Tartokoff, "Field Visit Report, Ohio," September 8 and 9, 1942, Folder 14-2-3-1(37), Box 950 Records of the Children's Bureau, RG 102, NARA.

<sup>53</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" Reeves, *Care and Education of Crippled Children*, 121-124.

<sup>54</sup> *Ibid.*

<sup>55</sup> Reeves, *Care and Education of Crippled Children*, 21-26.

crippled children in the early twentieth century, the number of convalescent homes in the United States steadily increased over time. In 1914, fourteen convalescent homes existed exclusively for the care of crippled children.<sup>56</sup> By 1924, there were forty-five homes and by 1930, there were seventy-three convalescent homes solely for the care of crippled children.<sup>57</sup>

An important feature of convalescent homes was the attention given to the psychological and emotional needs of crippled children. Convalescent home staff recognized that some crippled children suffered from hopelessness, depression, and helplessness because these children could not do the same things as typically developing children.<sup>58</sup> Additionally, some experts believed that parents or caregivers contributed to a child's emotional instability by being either overprotective or neglectful. Staff members tried to provide a home-like environment for children that included activities such as sports and dancing, training in manners and personal hygiene, and holiday parties.<sup>59</sup> Most homes also employed school teachers to provide group and individualized instruction to children in the areas of general education and vocational training.

Some convalescent homes specialized in care for children with specific diseases. TB sanatoria were the most common of these facilities. Efforts by the National Tuberculosis Association (NTA), founded in 1904, helped to increase awareness about

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<sup>56</sup> Reeves, *Care and Education of Crippled Children*, 2.

<sup>57</sup> Abt, *Care, Cure and Education*, 70-71; Reeves, *Care and Education of Crippled Children*, 2; White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

<sup>58</sup> McMurtrie, "The Care of Crippled Children," 532.

<sup>59</sup> Abt, *Care, Cure and Education*, 47; Culbertson, Winifred. "The Children's Convalescent Home: Cincinnati Sets New Standards of Care and of Cooperative Effort." *The American Journal of Nursing* 31, no. 9 (1931): 1017-1023.

children diagnosed with TB and promoted the development of sanitarium for these children across the United States. Starting in 1915, the NTA sponsored a series of influential child health programs that provided health education and medical clinics to diagnose and treat TB.<sup>60</sup> These programs brought hundreds of children crippled with bone TB into institutional care and helped to develop TB facilities exclusively for children.<sup>61</sup> In 1914, only one TB sanitarium existed for the exclusive care of children, but by 1924 over thirty-five such facilities operated throughout the United States. These sanitarium specialized in treatments considered beneficial to improved respiration in children such as light treatments, salt-water baths, and open-air classrooms and sleeping dormitories. In 1924, a report from the ISCC asserted that TB sanitarium were more successful in reduced disability among crippled children than any other type of orthopedic facility, with some sanitarium having recovery rates as high as 85% to 93%.<sup>62</sup>

*Custodial Care.* Also referred to as asylums, custodial care facilities served crippled children considered no longer treatable by medical experts. Physicians and orthopedic surgeons recommended placement in these facilities for children with the most severe disfigurements or most advanced stages of disease. Custodial facilities became similar orphanages for crippled children from families who could not afford the expensive care their conditions needed. Even the names of these facilities, such as the Virginia T. Smith Home for Incurables in Westport Connecticut or the New York City Home for Destitute Crippled Children, denoted a sense of abandonment. Custodial facilities offered only minimal medical care for the children and typically had fewer beds

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<sup>60</sup> Shyrock, R. H. *National Tuberculosis Association, 1904-1954: A Study of the Voluntary Health Movement in the United States*. New York, NY: National Tuberculosis Association, 1957.

<sup>61</sup> Abt, *Care, Cure and Education*, 47.

<sup>62</sup> *Ibid*, 49.

than convalescent homes.<sup>63</sup> Douglas McMurtrie, the director of the Red Cross Institute for Crippled and Disable Men and national expert in vocational rehabilitation, spoke out strongly against custodial homes. He argued that “the element which necessitates the special care of a crippled child is necessarily a physical defect or deformity. The first aim must therefore always be to remove this defect, and all other ends must if necessary be subordinated.”<sup>64</sup> As medical and surgical treatments improved during the twentieth century, the need for custodial facilities declined over time.<sup>65</sup> Table 5 (see page 39) provides data on the number of custodial facilities in the United States during the early twentieth century. In 1914, asylums for crippled children accounted for 28% of all institutions for crippled children. By 1924, they accounted for only 6% of all institutions and only 5% by 1930.<sup>66</sup>

### *Educational Programs*

As medical services and facilities developed for crippled children, health care professionals recognized that many of these children lacked the opportunity to attend school or receive an education. The first educational program for crippled children started at the Hospital for the Ruptured and Crippled in New York when Dr. Knight’s daughter volunteered to teach any child admitted to the hospital.<sup>67</sup> In the early 1900s, educators, especially those living in urban area, recognized the need to provide educational opportunities for crippled children. Most public schools could not accommodate the special physical needs of crippled children. Additionally, travel to and from school was difficult for children who could not walk. In 1918, the Commissioner of

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<sup>63</sup> Reeves, *Care and Education of Crippled Children*, 26.

<sup>64</sup> McMurtrie, “The Care of Crippled Children,” 530.

<sup>65</sup> Solenberger, *Crippled Children with Special Reference*, 4.

<sup>66</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

<sup>67</sup> Levine, “Hospital for Special Surgery,” 6.

the Federal Office of Education (FOE) wrote that "few States make any special provision for the care and education of crippled children, and in only a half a dozen cities are there separate schools or classes for them, and in the schools of most cities, towns and rural districts not even suitable seats and desks are provided for them."<sup>68</sup> In 1914, only eighty-four classrooms existed in the entire country that could accommodate the needs of crippled children. Similar to health care services, schools and classrooms for crippled children increased over the next two decades and by 1930, there were over five hundred classrooms devoted to the needs of crippled children. Table 6 shows the trend in the development of classrooms for crippled children in the United States during the early twentieth century. Public school authorities began to provide classrooms for crippled children, which had been initially operated by private agencies, especially in the large urban centers. For example, in 1913, the Board of Education for New York City assumed responsibility for forty-seven classrooms for crippled children that had been established as early as 1898 by such agencies as the Children's Aid Society of New York and the Guild for the Crippled Children of the Poor of New York City.<sup>69</sup> Public schools in other cities such as Baltimore, Chicago, Cleveland, Detroit and Philadelphia also began integrating crippled children into their systems in the 1910s.<sup>70</sup>

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<sup>68</sup> Solenberger, Edith Reeves. *Public School Classes for Crippled Children*. Bulletin, 1918, No. 10. Washington, DC: Government Printing Office, 1918.

<sup>69</sup> Guild for the Crippled Children of the Poor of New York City, "Second Annual Report", May 1898, 6, *Annual Reports*, Foundation for Child Development, 1909-1996 Microfilm Collection, RAC; Solenberger, *Public Schools Classes*, 9.

<sup>70</sup> Solenberger, *Public Schools Classes*, 9.

Table 6. School Attendance for Crippled Children, 1890-1930

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Date	Number of Classrooms for Crippled Children	Number of Students
1914	84	3,269
1924	362	6,225
1930	500	13,282

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Source: White House Conference on Child Health and Protection, *The Handicapped Child*, 154.

Several different types of educational programs developed for crippled children. Before working with the USCB, Edith Reeves Solenberger, a national authority on services for crippled children, outlined four major types of programs in a bulletin published by the Federal Office of Education (FOE) as part of the Office's annual bulletin series of 1918 (Bulletin, 1918, No. 10):

1. Cripples in regular classes;
2. Separate public school classes for cripples;
3. Instruction in hospitals;
4. Teachers sent to institutions for cripples.<sup>71</sup>

For programs that developed within public schools, the biggest challenges for educators included transporting crippled children to and from school and ensuring their safety while in the building. Crippled children often needed special equipment such as desks with adjustable seats, wheel chairs, and cots for rest periods. Additionally, school buildings needed modifications such as ramps or handrails to enable crippled children to move around the building. Some public schools worked with local private charities to accommodate the needs of crippled children. The Sunbeam Circle, a local women's charity organization in Cleveland, Ohio, provided transportation services when the Cleveland Board of Education built a new school for crippled children in 1910. Similarly, in New York City and Philadelphia, private charities and welfare agencies provided lunches for crippled children attending public schools.

Educational programs that developed in crippled children's hospitals and convalescent homes differed from school-based programs. Medical treatment took priority over educational needs, especially in hospitals. Convalescent homes, in contrast, offered more extensive educational programs because medical treatments were less

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<sup>71</sup> Solenberger, *Public Schools Classes*, 7-8.

invasive, but in both types of facilities, physicians, not educators, controlled the educational programs. A child participated in an educational program only if the physician considered it essential to the recovery process. Additionally, educational programs in facilities for crippled children often employed less rigorous standards than school-based programs. For example, some facilities used volunteers or nurses, rather than professional educators, to instruct children. Grades and student records were often not maintained well enough to ensure enrollment in a regular school when a child was discharged. Institutions for crippled children that experienced the most success with their educational programs were typically facilities that received governmental funding. State or local governments often stipulated cooperation with local school boards or mandated high standards of instructions to facilities receiving their funding.<sup>72</sup>

Despite the increases in the number and quality of educational programs for crippled children during the early twentieth century, crippled children received less education than children without crippling conditions. In 1918, Solenberger asserted that most crippled children were behind in their education.<sup>73</sup> Little had changed over a decade later when the White House Conference on the Health and Protection of Children in 1930 reported that 75% of crippled children observed in classrooms in six major cities failed to pass standardized tests appropriate for their age.<sup>74</sup> Educational experts blamed these discrepancies on the lack of access by crippled children to quality education. They argued for more educational programs in hospitals, other facilities, and in the homes of crippled children.

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<sup>72</sup> Solenberger, *Public Schools Classes*, 7-8.

<sup>73</sup> *Ibid.*, 8.

<sup>74</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 144.

### *Community-Based Services*

Not all crippled children received medical treatment in institutions. Some received assistance from community-based programs that offered a range of in-home and outpatient services. These programs included dispensaries and other types of outpatient clinics, foster care homes, summer camps, and home health nursing services. Outpatient services developed for a number of reasons. Some children did not need extensive surgical or medical treatment in a hospital or long stays in convalescent homes. Their conditions could be easily corrected through minor surgeries or by wearing braces or body casts for short periods. Institutional care was expensive. In 1914, the average annual cost for institutional care ranged from \$267 to \$570 per child (\$33,900 to \$72,500 in 2008 dollars).<sup>75</sup> Not all families could afford the care, nor could state governments or private agencies afford to provide treatment to all indigent crippled children. Further, the demand for services often drove the development of institutional care in communities. Predominately rural states had small numbers of crippled children and often could not support expensive treatment facilities. Similarly, so many crippled children lived in urban centers such as New York City, Cleveland, and Chicago, that the localities could not build enough facilities to accommodate all children. These factors contributed to an increase in community-based programs for crippled children during the early twentieth century. In 1914, approximately twenty-four dispensaries and in-home care agencies in the United States provided care exclusively to crippled children. By 1924, the number of

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<sup>75</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" Reeves, *Care and Education of Crippled Children*, 12.

programs increased to forty, and by 1930, there were over 130 community-based programs serving crippled children.<sup>76</sup>

Some of the first community-based services for crippled children developed in New York City. Local nursing agencies like the Henry Street Settlement Nursing Program, the Brooklyn Bureau of Charities' District Nursing Committee, and the Association for the Aid of Crippled Children provided home visiting services for crippled children discharged from the City's dispensaries or local orthopedic hospitals. Many of these children attended day school programs for crippled children. Two agencies, the Association for the Aid of Crippled Children and the New York Committee on After Care of Infantile Paralysis Cases, offer good examples of the development and diversity of community-based programs for crippled children in the early twentieth century.

*Association for the Aid of Crippled Children.* Established in 1908, the Association for the Aid of Crippled Children (AACC) advocated for educational opportunities for crippled children in New York City. By 1913, there were forty-seven classrooms for crippled children in the public schools of New York City.<sup>77</sup> The Association assisted crippled children with transportation to school and medical facilities, home nursing visits, and direct relief to families by purchasing needed medical equipment and nourishing food (for cases of rickets).<sup>78</sup>

The Association initially worked only with school-aged children, until the Board of Education in New York City assumed responsibility for all of the Association's

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<sup>76</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 153.

<sup>77</sup> Association for the Aid of Crippled Children, "Annual Report, 1913," 1913, 6, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC.

<sup>78</sup> Association for the Aid of Crippled Children, "Annual Report, 1915," 1915, 7, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC.

classrooms for crippled children in 1913.<sup>79</sup> No longer responsible for educational activities, the AACC conducted a series of surveys over the next two years and discovered that almost one-third of all crippled children in New York City had never received any treatment or care.<sup>80</sup> The Association shifted its focus to finding and accessing medical and social services for crippled children under the age of sixteen.

Under its new mission, the Association provided home nursing care for all crippled children in New York City, and promoted cooperation and referrals among other local agencies encountering crippled children. Preventive and medical care for crippled children held equal importance for the AACC. Examples of early preventive work by the Association's nurses included case finding of children in early stages of rickets and TB, and providing needed remedies, such as nutritional food or corrective equipment, for identified children. To promote their case finding model, AACC nurses worked cooperatively with other social welfare and public health agencies, such as local milk stations or day nurseries. Nurses would make regular visits to these agencies and encourage referrals from any child welfare agency. AACC Nurses were also known to stop crippled children on the street to inquire about their condition and arrange to meet with the family.<sup>81</sup> The new focus proved successful for the AACC. In 1915, the Association served 1,436 children with an annual budget of \$20,552 (equivalent to \$2.5

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<sup>79</sup> Association for the Aid of Crippled Children, "Annual Report, 1913," 1913, 6, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC.

<sup>80</sup> Association for the Aid of Crippled Children, "Annual Report, 1914," 1914, 5-7, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC.

<sup>81</sup> Association for the Aid of Crippled Children, "Minutes of Nurse Conference, March 11, 1920," 3, Folder 173, Box 18, Commonwealth Fund, RAC.

million in 2008 dollars), and by 1934, 3,985 children received services with an annual budget of over \$76,000 (\$5.3 million in 2008 dollars).<sup>82</sup>

*New York After Care Committees of Infantile Paralysis Cases.* The development of After Care Committees of Infant Paralysis Cases in New York offers another important example of early community-based programs for crippled children. The Committees organized treatment and services for children in New York following the 1916 polio epidemic. In New York City alone, over 2,400 children died from the disease and another 6,600 required specialized, long-term medical care that severely taxed local hospitals, dispensaries, and families' resources.<sup>83</sup> From 1916 to 1920, two After Care Committees (one for New York City and one for New York State) organized local health and social welfare services to create new services to meet the needs of crippled children and their families.

The New York Committee on After Care of Infantile Paralysis Cases (NYCACIPC) Committee included more than fifty members from local hospitals, dispensaries, local nursing agencies like the Henry Street Settlement Nursing Program and the Brooklyn Bureau of Charities' District Nursing Committee, and other social services organizations like New York Children's Aid Society and the New York Charity Organization Society. The Committee defined its mission as the facilitation of "after care of children recovering from poliomyelitis in co-operation with physicians and other

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<sup>82</sup>Association for the Aid of Crippled Children, "Annual Report, 1915," 1915, 12, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC; Association for the Aid of Crippled Children, "Annual Report, 1934," 1934, 22, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>83</sup>New York State Department of Health. *Thirty-Seventh Annual Report of the State Department of Health, Vol. 1*. New York, NY: New York State Department of Health, 1917, 402; "Committee on Appeal Letter," November 22, 1916, Folder 250, Box 24, Series Welfare Interest, RG 2, Rockefeller Family Archives, RAC.

existing agencies, and to encourage such additional provisions as may be found necessary and advisable.”<sup>84</sup> The NYCACIPC used nurses to follow-up with all cases of infantile paralysis in the city. A typical follow-up visit occurred in the child’s home and included the nurse observing the child’s status, educating parents about physicians’ medical recommendations, and providing muscle treatments or massages if needed.<sup>85</sup> After each home visit, nurses reported to the Committee about the child’s status and treatment plan. These reports provided information for the Committee’s central registry that tracked each case of polio from the 1916 epidemic.

Over its four years of operation, the Committee received referrals on over 8,000 polio cases.<sup>86</sup> Of these cases, 2,309 children (26%) were classified as cured due to treatment received through the Committee. Additionally, the Committee raised \$200,000 (\$11 million in 2008 dollars) which funded transportation services and braces for needy children.<sup>87</sup> From 1916 to 1918, the NYCACIPC purchased braces for over 2,300 children, at a total cost of about \$20,000 (\$1.2 million in 2008 dollars). To do this, the Committee bargained with local brace makers and physicians to accept the Committee’s set payments for braces, significantly reducing the cost and establishing standards of quality among local brace makers in New York City.<sup>88</sup> The Committee also organized transportation services for crippled children. In 1916, the NYCACIPC purchased several

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<sup>84</sup> “Report of the Executive Committee to the General Committee on After Care of Infantile Paralysis Cases,” August 17, 1916, 1, Folder 278, Box 25, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>85</sup> Wald to Greene, November 3, 1916, Folder 279, Box 25, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>86</sup> Murphy to Rockefeller, March 17, 1919, Folder 250, Box 24, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>87</sup> “Infantile Paralysis Summary,” 1918, Folder 275, Box 24, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC; Officer and Williamson, “Six Ways to Compute the Relative Value of a U.S. Dollar.”

<sup>88</sup> “Report of the Work of the New York Committee on After Care of Infantile Paralysis Cases,” June 28, 1917, 12, Folder 284, Box 25, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC; Riley to Vincent, April 19, 1918, 2, Folder 281, Box 25, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

ambulances at a cost of \$12,000 (\$1.1 million in 2008 dollars), and then collaborated with the New York City's Department of Charities to help transport crippled children to and from needed after care services. The Department of Charities provided drivers and maintained the ambulances while the After Care Committee processed the transportation requests from all over the city. At peak operation, approximately six hundred children received rides to medical appointments, hospital care, and other needed services each month, at a cost of approximately \$5500/month (\$355,000/month in 2008 dollars).<sup>89</sup>

For children with polio outside of New York City, the State Charities Aid Association's (SCAA) Special Committee on the After Care of Infantile Paralysis coordinated after care services in collaboration with the New York State Department of Public Health. About 3,000 cases of polio occurred in the rural areas of New York in 1916. Children living in these rural communities had limited access to specialized medical care compared to children living in New York City. To address this need, the SCAA Committee arranged for public orthopedic clinics that travelled throughout the state to provide medical care, finding it was more cost effective to bring services to the children. Orthopedic surgeons and nurses employed by the State Health Department staffed the clinics, and only for severe cases of polio did the Committee send children to New York City for treatment and convalescent care. In the first year of operation (1916-1917), the SCAA Committee sponsored 146 clinics, providing examinations and medical care to over 2,500 children.<sup>90</sup>

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<sup>89</sup> "Report of the Work of the New York Committee on After Care of Infantile Paralysis Cases," June 28, 1917, 12, Folder 284, Box 25, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>90</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" "Report of the Special Committee on the After care of Infantile Paralysis, October 1, 1916 to October 1, 1917," 2, Folder 288, Box 26, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

An important feature of the SCAA Committee's after care program was the use of social workers to coordinate services for the children, instead of nurses. The SCAA modeled these services after a 1907 TB program that was developed in cooperation with the New York State Health Department. In this model, the State Health Department provided medical and in-home nursing care to patients and the SCAA provided all social services and coordinated relief efforts.<sup>91</sup> For the After Care program, the SCAA reassigned some full-time social work staff to work with crippled children and utilized social workers from existing child welfare programs already established in some New York counties.<sup>92</sup> As a result, each county affected by the polio epidemic in New York State had a social worker responsible for coordinating the after care services. These social workers travelled with public orthopedic clinics to track patients' progress, assess eligibility for braces and other needed medical equipment, coordinate relief needs, and ensure that children received appropriate after care.<sup>93</sup> In a progress report, the SCAA's secretary, Homer Folks, remarked that the "social deficiencies of the families in which after care work is being done such as intemperance, shiftlessness, incompetency and mental deficiency...brings to light the full extent of the social work required and increases the burden upon the agencies dealing with the social aspects of the undertaking."<sup>94</sup> In contrast, the NYCACIPC provided only limited social services

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<sup>91</sup> Folks to Greene, October 3, 1916, Folder 285, Box 26, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>92</sup> Folks to Greene, September 13, 1916, Folder 285, Box 26, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>93</sup> "Report of the Special Committee on the After-Care of Poliomyelitis of the State Charities Aid Association," January 30, 1917, Folder 288, Box 26, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC; Folks to Greene, September 13, 1916, Folder 285, Box 26, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

<sup>94</sup> Folks to Embree, February 15, 1917, Folder 286, Box 26, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

through the social work departments of area hospitals, and most children in New York City did not receive follow-up care from social workers in the home.<sup>95</sup>

The After Care Committees on Infantile Paralysis Cases in New York were an important public health effort on behalf of crippled children in the early twentieth century. Most Progressive Era reform efforts for crippled children during the 1910s and 1920s focused on developing services within institutional and educational settings.<sup>96</sup> The New York After Care Committees, however, specifically worked to coordinate and develop community-based services to reach children with disabilities in their homes and communities. In addition, the Committees worked to mobilize and change systems of care in New York as well as provide direct care to individual children. Important practices that developed from the Committees included transportation services, a centralized registry and referral system, and the recognition of social work as an important profession in the work for crippled children. Several of these practices became standard care for crippled children in later years, and would become required services under the federal CCS program almost two decades later.

#### *Civic and Fraternal Organizations*

During the early decades of the twentieth century, members of fraternal and civic organizations, such as Rotary, Shriner, and Elks Clubs, began campaigning to improve the lives of crippled children. Most of these organizations cited humanitarian concerns and community service as their primary reasons for helping crippled children, but these efforts may have also increased membership and improved public relations for the

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<sup>95</sup> Wright, *Survey of Cripples in New York City*, 17.

<sup>96</sup>Byrom, Brad. "The Progressive Movement and the Child with Physical Disabilities." In *Children with Disabilities in America: A Historical Handbook and Guide*, edited by Philip L. Safford and Elizabeth J. Safford, 49-64. Westport, CT: Greenwood Publishing Group, 2006.

organizations.<sup>97</sup> Many fraternal organizations during the early twentieth century developed social and medical services such as orphanages, hospitals, and medical clinics as benefits to their members, and only members and their families were eligible for these services.<sup>98</sup> However, services for crippled children appeared the exception to this trend. For example, the Shriners opened their Hospitals for Crippled Children to any crippled child needing medical care, and the New Jersey State Elks' Association actively worked with other non-fraternal organizations to provide services to crippled children and adults throughout the state.<sup>99</sup> Typical services provided by fraternal and civic groups included medical care for crippled children at sponsored clinics or hospitals, state or local surveys of crippled children, and legislative advocacy to establish city, county or state-sponsored programs.

*International Society for Crippled Children.* In the 1910s, the Ohio Rotary Club was one of the first civic groups in the United States to work with crippled children. One of its members, Edgar "Daddy" Allen, became interested in improving health care for all children after the death of his son due to a street car accident in 1905. Allen used his wealth and political influence to establish a hospital in Elyria, Ohio where he encountered many crippled children. In 1919, he founded the Ohio Society for Crippled Children

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<sup>97</sup> New Jersey State Elks' Association, *Report of the New Jersey State Elks' Crippled Kiddies Committee*. Asbury, NJ: New Jersey State Elks' Association, 1925; "Ancient Arabic Order of the Nobles of the Mystic Shrine." In *Fraternal Organizations* edited by Alvin J. Schmidt, 308-310. Westport, CT: Greenwood Press, 1980.

<sup>98</sup> Beito, David T. *From Mutual Aid to the Welfare State: Fraternal Societies and Social*. Chapel Hill, NC: The University of North Carolina Press, 2000.

<sup>99</sup> New Jersey State Elks' Association, *Report of the New Jersey State Elks' Crippled Kiddies Committee*, 7; Potts, Florence J. "The Shriners' Hospitals: A General Outline of the History of the Founding of the Shriners' Hospitals for Crippled Children." *The American Journal of Nursing* 26, no. 10 (1926): 745-752.

(OSCC) with other members from the Ohio Rotary Club.<sup>100</sup> Their first order of business was to advocate for a state-funded crippled children's program in Ohio, which was also established in 1919. The "Ohio Plan" quickly developed into a model state program for crippled children.<sup>101</sup> Orthopedic hospitals and clinics provided medical care to crippled children throughout the state, and local convalescent homes and health department nurses provided follow-up care. Within ten years, the "Ohio Plan" increased the number of crippled children receiving treatment under the program from fifteen children in 1920 to over 1500 children in 1930.<sup>102</sup>

Following their success in developing services in Ohio, Allen and the OSCC formed a national advocacy organization, the International Society for Crippled Children (ISCC), in 1921. In its early years, the ISCC focused on developing its organizational structure by establishing local affiliate groups and a professional advisory council that included specialists in orthopedic surgery, nursing, and social work.<sup>103</sup> By 1928, the Society had twenty-eight state-level societies and one in Canada. Many of the ISCC's affiliate groups sponsored the development of crippled children services in their own states. The Alabama Society for Crippled Children (ASCC), established in 1926, coordinated the services of three different state-level departments to provide medical and educational programs for crippled children. The Alabama State Departments of Health, Child Welfare, and Education each allocated money and personnel to work with crippled children in hospitals and clinics all over the state. By 1928, the ASCC and its partners screened over 2,000 children in orthopedic clinics and provided medical treatment to over

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<sup>100</sup> "The National Easter Seal Society for Crippled Children and Adults," Chambers, Clarke A., and Peter Romanofsky, eds. *Social Service Organizations*. 2 vols. Westport, CT: Greenwood Press, 1978, 623.

<sup>101</sup> Smith, *The Crippled Child*, 2.

<sup>102</sup> *Ibid*, 31.

<sup>103</sup> "The National Easter Seal Society," Chambers and Romanofsky, 528.

1,200 crippled children throughout the state.<sup>104</sup> The ASCC program became the foundation for the state's Title V CCS program developed by the State of Alabama in 1936.<sup>105</sup>

In the 1930s, the ISCC began advocating for a federal health and education program for crippled children. The Society lobbied for the inclusion of sessions about crippled children at the 1930 White House Conference on Child Health and Protection.<sup>106</sup> In 1931, the ISCC promoted the passage of Senate Bill 6227, which would have authorized the Federal Board for Vocational Education to provide state funding for medical, educational, and vocational rehabilitation services to crippled children. Established in 1917, the Federal Board for Vocational Education was responsible for overseeing federal grants to states for vocational education services for disabled World War I veterans.<sup>107</sup> In his testimony to the Senate Committee on Education and Labor on February 28, 1931, Allen stated that "if we can organize each State and have Federal aid that will guide the work...half of our crippled children that we have to-day can come to the adult age with the deformity possibly removed."<sup>108</sup> Although the bill did not pass, the ISCC continued to support federal aid for crippled children. In 1935, members of the ISCC testified in favor of provisions for crippled children in Title V of the SSA.<sup>109</sup>

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<sup>104</sup> The Alabama Society for Crippled Children, "Annual Report of the Alabama Society for Crippled Children," 1929, 2, Folder 65, Box SG006938, Public Information General Files, Alabama Department of Archives and History, Montgomery, Alabama (hereafter designated ADAH).

<sup>105</sup> Couch, Robert Hill, *Every Day is Easter in Alabama: The History of the Alabama Society for Crippled Children and Adults, 1926-1976*. Troy, AL: Troy State University Press, 1976.

<sup>106</sup> "The National Easter Seal Society," Chambers and Romanofsky, 528; Howett, Harry H. "The White House Conference Program for Crippled Children." *Hospital Social Service* 22 (1930): 121-134.

<sup>107</sup> Holt, William Stull. *The Federal Board for Vocational Education: Its History, Activities and Organization*. D. Appleton and Company: New York, NY, 1922.

<sup>108</sup> US Senate Committee on Education and Labor. *Rehabilitation and Vocational Education of Crippled Persons: Hearing before the Committee on Education and Labor on S. 6227, 71<sup>st</sup> Cong., 3<sup>rd</sup> sess., 1931, 14.*

<sup>109</sup> US House Committee on Ways and Means. *Economic Security Act: Hearing before the Committee on Ways and Means on HR. 4120, 74<sup>th</sup> Cong., 1<sup>st</sup> sess., 1935, 541*

*Fraternal Organizations.* During the early twentieth century, the Shriners and the Elks were the two most prominent fraternal organizations involved with the care of crippled children. In 1921, the Shriners adopted a proposal at their annual conference to establish a hospital for crippled children. Prior to this, the Shriners had not participated in charitable community work. W. Freeland Kendrick, a national officer in the Shrine, recommended the project based on his personal study of the issues related to crippling conditions among children. The goal was to provide the best possible medical care, free of charge, to qualified crippled children. The first Shriners' Hospital for Crippled Children opened in 1922 in Shreveport, Louisiana.<sup>110</sup> The Shriners erected thirteen additional hospitals for crippled children during the next five years. Services at these hospitals included surgical and medical treatment, nursing services, physical therapy, and the provision of medical equipment. By 1929, the Shriners' hospitals had provided inpatient care to over 8,000 crippled children and outpatient care to over 19,000 children.<sup>111</sup>

In the 1920s, the Benevolent and Protective Order of Elks promoted programs for crippled children in five states, New York, New Jersey, Illinois, Pennsylvania and Washington. The most successful was the New Jersey State Elks' Crippled Kiddies Committee.<sup>112</sup> Each of the New Jersey Elks' fifty-two lodges operated programs under the Crippled Kiddies Committee. Some lodges paid local physicians to provide medical and surgical care, others hired nurses to provide in-home care, and some operated outpatient orthopedic clinics. Most lodges provided social activities for crippled children

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<sup>110</sup> "The Shriners' Hospitals for Crippled Children: Behold How Great a Matter a Little Fire Kindleth." *Journal of Bone and Joint Surgery* 4 (1922): 135-136.

<sup>111</sup> McCollough, Newton C. "The Evolution of Shriners Hospitals for Children in North America." *Clinical Orthopaedics and Related Research*, 374 (2000): 187-94.

<sup>112</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 157.

such as summer camps and holiday parties. In 1925, the New Jersey Elks identified 711 new cases of crippled conditions among children in their state, and funded medical care for almost four hundred crippled children in New Jersey, including 396 operations, over 20,000 nursing visits, and 319 sets of braces.<sup>113</sup> In 1932, the New Jersey program was promoted as a national model for all Elks' lodges throughout the country.<sup>114</sup>

### *State-Funded Programs for Crippled Children*

As programs for crippled children grew in urban areas through the efforts of private citizens and charitable groups, so did the interest of state governments in the welfare of crippled children. By 1934, thirty-seven states (77% of the 48 states) had state-level CCS programs, and thirty-five states had public appropriations totaling an estimated \$5.5 million dollars for these services (\$493 million in 2008 dollars).<sup>115</sup> The actual reported state and county public funding for services for crippled children totaled \$3.7 million dollars (\$332 million in 2008 dollars) by twenty-three state programs.<sup>116</sup> The amounts appropriated varied greatly from state to state, from \$2,500 per year (\$224,000 in 2008 dollars) in South Dakota to over \$1 million per year (\$89 million in 2008 dollars) in New York State.<sup>117</sup> Additionally, in eleven states, counties contributed funding to local crippled children's programs. Typical services provided by state-level programs included case finding and registration of crippled children, outpatient clinics,

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<sup>113</sup> New Jersey State Elks' Association, *Report of the New Jersey State Elks*, 6.

<sup>114</sup> New Jersey State Elks' Association "Crippled Children Work: New Jersey Plan Warmly Commended to all Lodges of the Order," June 1932, 1, Folder Crippled Children, Box 395, Library and Research Bureau Papers, 1928-1933, Democratic Party National Committee Papers, Franklin Delano Roosevelt Presidential Library, Hyde Park, New York (hereafter referred to as FDR Library).

<sup>115</sup> Committee on Economic Security, *Social Security in America*. Washington, DC: US Government Printing Office, 1937, 285-286; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>116</sup> *Ibid.*

<sup>117</sup> Committee on Economic Security, *Social Security in America*, 285; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

surgical and medical care in hospitals, and convalescent care. Many different types of state agencies administered services for crippled children. Table 7 reports the number of state agencies in 1934 responsible for crippled children programs by type of agency. Most frequently, states placed administrative responsibility for crippled children's programs in one agency. Sometimes, two or more state departments collaborated to provide services. Often, these included state departments of education, health, and sometimes a state crippled children's commission, a state child welfare department, or a voluntary crippled children's organization. The involvement of multiple state agencies reflected the complicated nature of care for crippled children who needed medical and social care as well as educational services.<sup>118</sup>

In 1925, the USCB initiated one of the first studies of state governmental services for crippled children.<sup>119</sup> The Bureau hired Edith Reeves Solenberger, a social worker and expert on crippled children, to investigate state-level government programs of services for crippled children.<sup>120</sup> This study was in keeping with the Bureau's responsibilities to "investigate and report... upon all matters pertaining to the welfare of children."<sup>121</sup> By the mid-1920s, the Bureau had completed studies on state agencies and legislation related to child labor, mother's pensions, child welfare programs, and infant and maternal mortality, but this would be its first investigation related to crippled children.<sup>122</sup> The Bureau pursued the investigation because of the growing national interest from families and professionals about crippled children and the numerous inquiries coming to the

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<sup>118</sup> Committee on Economic Security, *Social Security in America*, 285.

<sup>119</sup> United States Children's Bureau, *Thirteenth Annual Report of the Chief of the Children's Bureau*. Washington, DC: US Government Printing Office, 1925, 5.

<sup>120</sup> Reeves, *Care and Education of Crippled Children*; Solenberger, *Public Schools Classes*.

<sup>121</sup> United States Children's Bureau, *The Establishment of the Children's Bureau*. Washington, DC: Government Printing Office, 1912.

<sup>122</sup> United States Children's Bureau, *Thirteenth Annual Report*, 5.

Table 7. Types of State Agencies Administering Crippled Children's Services in 1934 (37 total states)

Type of State Agency	Number of Agencies
Education	2
Public Health	6
Crippled Children's Commission	3
State Hospital	5
Public Welfare	5
Other (Boards of Control, Dept. of Institutions)	5
Unknown	2
Two or more Agencies	9

*Source:* Committee on Economic Security, *Social Security in America*, 285.

Bureau requesting information about crippled children. In the Bureau's *1925 Annual Report*, Chief Grace Abbott stated that because of the numerous inquiries, "the bureau, therefore, has undertaken a survey of provisions in [sic] behalf of crippled children in eight States representing different sections of the country and both rural and densely populated regions."<sup>123</sup>

Some inquires that came to the Bureau were directly from family members and caregivers seeking help for their own children. Other letters requesting assistance came from local and state agencies that wanted information on how best to develop services. In December 1925, Henrietta Lund, Director of the Children's Bureau in North Dakota, wrote the USCB for help in creating crippled children's services for her state. She inquired if "...clinics will be advisable in view of the fact that there is a lack of facilities for orthopedic surgery in the state."<sup>124</sup> Assistant Bureau Chief Katherine Lenroot referred Lund to an expert outside the Bureau, noting "...we have no printed materials as yet on this subject."<sup>125</sup> Often the USCB referred such requests to the ISCC. The Bureau considered the Society "one of the best sources of information in regard to activities for crippled children."<sup>126</sup>

Solenberger's report on programs for crippled children was completed in 1928, but was never published. Although it is unclear why the report remained unpublished, the Bureau's financial resources declined in the following years due to the economic

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<sup>123</sup> *Ibid.*, 6.

<sup>124</sup> Lund to Lundberg, December 17, 1925, Folder 7-5-5-3, Box 295, Records of the Children's Bureau, RG 102, NARA.

<sup>125</sup> Lenroot to Lund, December 22, 1925, Folder 7-5-5-3, Box 295, Records of the Children's Bureau, RG 102, NARA.

<sup>126</sup> Abbott to Perry, November 6, 1928, Folder 7-5-5-3, Box 295, Records of the Children's Bureau, RG 102, NARA.

down turn of the early 1930s, limiting its ability to publish reports.<sup>127</sup> Additionally, the Bureau's research focus shifted to the impact of the Great Depression on the health and well-being of American children. Nevertheless, the information compiled from the study proved valuable when Abbott and Lenroot recommended programs for women and children to the Committee on Economic Security (CES) in 1934.<sup>128</sup>

In her report, Solenberger described two main types of state-funded programs for crippled children. The first was a centralized plan where services were provided in one institution located within the state, either a general hospital or specialty orthopedic hospital. States with centralized programs included Iowa, Indiana, and Nebraska. Children needing care travelled to the state facility for medical care, and often remained far away from family and friends for months at a time. Advantages of these centralized programs included highly trained orthopedic physicians and nurses who worked only with crippled children, state-of-the-art medical care, opportunities for medical research studies, and a centralized program administration. However, these programs typically lacked sufficient outpatient clinics throughout the state to provide diagnostic or follow-up services. Additionally, families and children found transportation to a state facility difficult and expensive. Some states covered transportation costs, but it was a significant proportion of a program's budget. Further, state-run hospitals experienced long wait lists because children received both surgical and convalescent care in the same facility. Of the more than 5,000 crippled children on waiting lists for hospital care in 1934, most lived in a state with a centralized program.<sup>129</sup> The state facility in Indiana, the Robert H. Long

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<sup>127</sup> United States Department of Labor, *Twenty-second Annual Report of the Secretary of Labor*, Washington, DC: US Government Printing Office, 1934.

<sup>128</sup> Committee on Economic Security, *Social Security in America*, 286.

<sup>129</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 159-160.

Hospital, dealt with its long waiting list by discharging children home as quickly as possible and referring all cases to the Social Service Department of Indiana University. Social workers from the department corresponded via mail with children and their families from all over the state to encourage follow-up medical care at the City Dispensary in Indianapolis.<sup>130</sup>

The other type of state program, referred to as a decentralized plan, worked by paying for the care of crippled children in multiple locations throughout the state. The state agency responsible for crippled children's services maintained a list of qualified hospitals, orthopedic surgeons, and outpatient clinics that could receive reimbursement for treating children.<sup>131</sup> States with decentralized plans included Ohio, Vermont, and Kentucky. Because many hospitals and physicians could provide services, crippled children did not have to travel far from home for medical and convalescent care. Most decentralized programs employed an orthopedic surgeon to provide surgical care, and general acute hospitals and general medical practitioners throughout these states also provided medical care to crippled children, especially after care treatment. Other advantages of decentralized programs included high levels of collaboration among state agencies and private charities on crippled children's services. Ohio's plan mandated its State Departments of Education, Health, and Welfare to work cooperatively.<sup>132</sup> The State Department of Education provided classrooms for crippled children while the Department of Health operated outpatient clinics and collected data. The Department of Welfare assisted indigent crippled children with accessing care. Additional support came from local governments and private charities like the Rotary Club and the OSCC. For

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<sup>130</sup> Hare, *A Study of Handicapped Children*, 8.

<sup>131</sup> Solenberger, *Crippled Children with Special Reference*, 13-17.

<sup>132</sup> Smith, *The Crippled Child: The Ohio Plan*, 9.

example, the Rainbow Hospital for Crippled and Convalescent Children in Cleveland started in 1890 as a summer camp funded by private donations. By 1922, in addition to the summer camp, the hospital also operated a seventy-five bed facility funded by both private and public monies.<sup>133</sup>

Solenberger's report also noted that most state programs for crippled children included both centralized and decentralized features in their plans. For example, New York State operated a state-run crippled children's hospital for indigent children, but in 1925, the State started paying for care at other crippled children's hospitals to reduce the long waiting list at the state facility.<sup>134</sup> While Solenberger favored the development of decentralized plans for crippled children's services, more emphasis was placed on the importance of creating state systems of coordinated medical care for crippled children. Solenberger wrote that "coordinated state plans should be developed in every state."<sup>135</sup> Other features recommended for state-level crippled children's programs included services to prevent crippling conditions, case finding methods, orthopedic clinics with diagnostic and training programs, social work services, and more emphasis on mental health needs of children with physical handicaps.<sup>136</sup>

## Conclusion

In the United States, the period from 1890 to 1934 marked an increase in both quality and quantity of services for crippled children at the state and local levels. The number of institutions and agencies serving children with physical defects grew during

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<sup>133</sup> Wilson, Mary Blythe. "Cleveland Women's Enterprise in Care of Convalescent Children." *The Modern Hospital* 19, no. 6 (1922): 486-489.

<sup>134</sup> Solenberger, *Crippled Children with Special Reference*, 18.

<sup>135</sup> *Ibid*, 8.

<sup>136</sup> *Ibid*, 11-14.

the period. Available medical treatments improved as did the training of professionals working with crippled children such as orthopedists, nurses, social workers, and educators. Additionally, local and state-level public health and child welfare agencies learned to identify and accommodate crippled children in their systems of care. Professionals and child health advocates acknowledged the need for national funding and coordination to improve and expand services to all crippled children in the United States.

## CHAPTER 3

### TRANSITION FROM STATE AND LOCAL EFFORTS TO A NATIONAL PROGRAM

*“Federal [aid] is to-day necessary to bring about a coordinated and unified program that really brings in those entire needs of the cripple and provides a way to meet all those needs, because if you meet just part of them and do not go all the way through your program is deficient.”*

Edgar “Daddy” Allen, President of the International Society for Crippled Children, February 28, 1931<sup>1</sup>

Until his death in 1937, Edgar “Daddy” Allen advocated for a federal system that would adequately fund and coordinate medical and social care for crippled children. He outlined his vision as a “program for the prevention of crippling conditions, the finding of the crippled child, its care, treatment and education, and finally, its placement in the life of the World.”<sup>2</sup> Allen’s vision came from humble beginnings. In 1915, he helped establish the Gates Hospital for Crippled Children in Elyria, Ohio, a small town of about 8,000 people. Over the next thirty years, Allen influenced the development of a state-wide crippled children’s program in Ohio, founded the International Society for Crippled Children (ISCC), and petitioned the United States Congress to fund educational and medical programs for crippled children. Due to poor health, Allen was unable to participate in the development of the Social Security Act in 1934; but his successor with the ISCC, Harry Howett, then Executive Secretary of the Society, did testify before

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<sup>1</sup> US Senate Committee on Education and Labor. *Rehabilitation and Vocational Education of Crippled Persons: Hearing before the Committee on Education and Labor on S. 6227, 71<sup>st</sup> Cong., 3<sup>rd</sup> sess., 1931, 15.*

<sup>2</sup> International Society for Crippled Children, “The Crippled Child’s Bill of Rights,” 1931, 1, Folder ISCC, Box 42, Franklin D. Roosevelt: Papers as Governor of New York, 1929-32, FDR Library.

Congress about the importance of federal services for crippled children. Allen's work offers a good example of the transformation of services for crippled children from local to national programs in the United States during the early twentieth century.

### *A Growing National Interest in Saving Crippled Children*

As discussed in Chapter 2, all types of services for crippled children developed and expanded at state and local levels in the United States from the late 1800s to the 1930s. Private citizens, social reformers, and government officials worked together to develop and organize these services. Health care professionals, such as orthopedic surgeons and nurses, supported the creation of new hospitals or clinics as a way to provide services for crippled children and to secure the means to practice and promote their profession. Public officials brought about legislation and policy changes within local and state governments to fund and mandate crippled children's programs. Over time, these child health advocates and social reformers began a national dialogue about the needs and rights of crippled children. They believed it was no longer enough to sponsor annual fund raising events to support local orthopedic clinics for crippled children, and began advocating for the creation of a federal program to coordinate and fund medical and social services for crippled children.

Two national conferences provided important venues for those interested in speaking out about the needs of children during the late nineteenth and early twentieth centuries: the White House Conferences on Children; and 2) the National Conference of Social Work (NCSW). Different presidents, starting with Theodore Roosevelt, sponsored the White House Conferences on Children, which were held every ten years starting in 1909 and ending in 1970. In 1979, President Jimmy Carter called for the next conference

to be convened in 1981, but newly elected President Ronald Reagan cancelled the national conference in favor of state-level conferences.<sup>3</sup> Today, advocates for children are campaigning for a White House Conference on Child Welfare in 2010.<sup>4</sup>

Only three of the White House Conferences occurred prior to passage of the Social Security Act in 1935: 1) the 1909 White House Conference on the Care of Dependent Children; 2) the 1919 White House Conference on Standards of Child Welfare; and, 3) the 1930 White House Conference on Child Health and Protection. Each conference focused on various issues related to American children such as child labor, child welfare, and health care.<sup>5</sup> In contrast, the NCSW met annually, and was organized by social workers and other social welfare professionals interested in improving public and private social services to all Americans.<sup>6</sup> The NCSW first met in 1874 as the Conference of Boards of Public Charities, and its name changed numerous times over the next eighty years (the Conference of Charities from 1875 to 1879; the Conference of Charities and Correction from 1880 to 1881; the National Conference of Charities and Correction from 1882 to 1916; the National Conference of Social Work from 1917 to 1956; and the National Conference on Social Welfare from 1957 to 1983). While the Conference ended in 1983, for over a hundred years it served as forum for social reformers, public administrators, academics, and social service professionals to present and discuss ideas related to public programs and policies in a variety of areas

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<sup>3</sup> Zigler, E. "Reinstituting the White House Conference on Children." *The American journal of orthopsychiatry* 63, no. 3 (1993): 334-6.

<sup>4</sup> "CWLA Calls on President Barack Obama to Convene a White House Conference on Children and Youth in 2010," Child Welfare League of America <http://www.cwla.org/advocacy/whitehouseconf10.htm>; Raphael, Sally. "Eye on Washington: 2010 White House Conference on Children and Youth." *Journal of Child and Adolescent Psychiatric Nursing* 21, no. 4 (2008 dollars): 247-248.

<sup>5</sup> Beck, Rochelle. "The White House Conference on Children: A Historical Perspective." *Harvard Educational Review* 43, no. 4 (1973): 653-668.

<sup>6</sup> Bruno, Frank John, *Trends in Social Work, 1874-1956: A History Based on the Proceedings of the National Conference of Social Work*. New York, NY: Columbia University Press, 1957.

such as public health, child welfare, institutional care, poverty, and criminal justice. A review of each of the conferences' proceedings provides a better understanding of the national conversation about gaps surrounding programs and policies for crippled children. See Appendix A for a detailed description of the methodology used to analyze the proceedings of these two conferences.

*Proceedings of the White House Conferences for Children (1909 - 1930)*

President Theodore Roosevelt convened the first White House Conference on Children in January 1909 following encouragement from Jane Addams, Lillian Wald, and other prominent leaders in the settlement house movement. The conference's goal was to highlight and improve the role of the federal government in the care and treatment of children.<sup>7</sup> Conference participants considered crippled children one of many types of dependent and needy children, but the care and treatment of crippled children was a minor theme at the conference. Of the dozens of addresses and speeches given, only one was entirely devoted to the needs of crippled children, and only three other presentations briefly mentioned children with physical handicaps. Most of the discussion focused on the role of institutions in the care and treatment of crippled children. This is in contrast to the general recommendations of the conference that "home life is the highest product of civilization....children should not be deprived of it except for urgent and compelling reasons."<sup>8</sup> In his opening remarks to the conference, President Roosevelt said that crippling and deforming conditions were a reason to separate a child from his or her

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<sup>7</sup>Beck, "The White House Conference on Children,"655.

<sup>8</sup> *Proceedings of the Conference on the Care of Dependent Children, Held at Washington, D.C., January 25, 26, 1909* (hereafter cited as *Proceedings 1909 White House Conference*), US Senate Document 721, 60<sup>th</sup> Cong., 2d sess., 1909, 9

family because care and proper treatment could typically not be provided in the home environment.<sup>9</sup>

The sole presentation on crippled children was delivered by Dr. Newton M. Shaffer, an orthopedic surgeon associated with the Cornell University Medical College and the New York State Hospital for the Care of Crippled and Deformed Children. In his presentation, Dr. Shaffer advocated for the role of hospitals and convalescent homes for crippled children. He noted that “the larger portion of this dependent class [of children] needs hospital care for a prolonged period.”<sup>10</sup> Dr. Schaffer not only recommended institutional care for crippled children, he offered specific professional opinions about the quality and breadth of services within these institutions. For instance, the institution should carefully select the number and type of children admitted as a means to control the environment as much as possible. He stated that the institution should reflect the home as much as possible, and cautioned that bringing together too many dependent and neglected children could affect their overall morale. He stressed that institutions for crippled children should focus on medical and surgical treatment first, and then rehabilitation work such as educational and vocational training services. He stated that educational programs should be provided only if the child was physically able and with an appropriate assessment of skills and needs. Dr. Shaffer also lamented the lack of statistical data about crippled children, both nationally and locally. He noted the importance of data in planning for health care programs for children, and asserted that there were many crippled children throughout the United States in need of services

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<sup>9</sup> *Proceedings 1909 White House Conference*, 36.

<sup>10</sup> *Proceedings 1909 White House Conference*, 82.

(concluded only from anecdotal information). Dr. Schaffer's remarks about data would be echoed by many other professionals in the coming decades.

Sponsored by President Woodrow Wilson, the 1919 White House Conference on Standards of Child Welfare set out to establish standards of treatment and policy for child welfare programs across the country.<sup>11</sup> At the time, state laws were diverse, and child health and welfare programs varied from state to state. While none of the conference participants were associated with crippled children's programs, several mentioned the needs of crippled children in relation to broader programs for dependent and neglected children. One presenter, Robert W. Keslo, the executive director of the Massachusetts State Board of Charity, stressed that all state governments should assume responsibility for the care and treatment of crippled children.<sup>12</sup> Another presenter, W.W. Hodson of the Minnesota Children's Bureau, described how the state of Minnesota had consolidated most of its child welfare programs under the State's own Children's Bureau, including programs for the care and treatment of crippled children.<sup>13</sup> Conference participants recommended the inclusion of crippled children as a special class of protected children in state laws and the development of state vocational or educational rehabilitation programs for crippled children within the state's Department of Education.<sup>14</sup> Three participants endorsed the prevention and screening of diseases or conditions related to crippling conditions such as tuberculosis (TB) and malnutrition. Specific recommendations included using medical services in schools and local physicians as a way to screen and diagnose for crippling conditions, and increased medical training for physicians on the

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<sup>11</sup> United States Children's Bureau, *Standards of Child Welfare: A Report of the Children's Bureau Conferences, May and June 1919*. Washington, DC, US Government Printing Office, 1919.

<sup>12</sup> United States Children's Bureau, *Standards of Child Welfare*, 307-312.

<sup>13</sup> *Ibid*, 420-426.

<sup>14</sup> *Ibid*, 93-96, 307-312.

role of nutrition in the treatment of crippled children.<sup>15</sup> Despite these recommendations, only six of sixty presentations at the conference mentioned crippled children, suggesting that most conference participants did not place high priority on the needs of crippled children.<sup>16</sup>

Crippled children played a small role in the first two White House Conferences on Children for three reasons. First, the conferences focused less attention on child health care compared to other issues such as child labor, juvenile delinquency, and the standardization of child welfare laws. For example, of the fourteen recommendations made by the 1909 Conference, only one addressed the health needs of children.<sup>17</sup> The 1919 Conference devoted more time to child health than the 1909 Conference, but covered topics related to infancy and maternity rather than the health care needs of crippled children. Second, few of the participants at either conference were associated with crippled children's institutions, hospitals, or public health programs. Only five of the 180 participants at the 1909 Conference were medical doctors and about one-third of the presenters at the 1919 Conference were physicians (twenty-one of sixty-two presenters). Dr. Shaffer was the only orthopedic surgeon and the only presenter associated with a crippled children's program at either conference.<sup>18</sup> Third, the 1909 conference predated two of the major child health reform efforts of the early twentieth century, the establishment of the United States Children's Bureau (USCB) in 1912 (a recommendation of the 1909 conference), and the creation of after care programs for child survivors of the 1916 polio epidemic. Both the 1909 and the 1919 conferences

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<sup>15</sup> *Ibid*, 86-90, 238-243, 248-255.

<sup>16</sup> United States Children's Bureau, *Standards of Child Welfare*, 3-6.

<sup>17</sup> *Proceedings 1909 White House Conference*, 80-82.

<sup>18</sup> *Ibid*, 20-31.

predated the Sheppard-Towner Maternity and Infancy Protection Act of 1921. However, during the 1919 White House Conference, Dr. S. Josephine Baker, a pediatrician and Director of the Child Hygiene Division at the New York City Health Department, supported the idea of federal legislation in the United States similar to the 1918 National Maternity Act passed in England, which supported public national health care for pregnant women and newborn infants.<sup>19</sup>

The 1930 White House Conference on Child Health and Protection represented a major change from the two previous conferences. President Herbert Hoover announced the conference in 1929, but it was actually convened over a year later to allow time for the preparation of research reports on such issues as infant mortality, education, delinquency, and handicapping conditions.<sup>20</sup> In his announcement of the conference, Hoover emphasized the importance of “complete and exhaustive advanced study of the facts and forces in progress, of the experience with the different measures and the work of organizations both in voluntary and official fields.”<sup>21</sup> Over twelve hundred academics and professionals worked on 150 committees and sub-committees to prepare these reports. President Hoover’s interest in the health and welfare of American children was probably influenced by his work with the American Child Hygiene Association (ACHA), a voluntary child health organization established in 1908. Appointed president of ACHA in 1921, Hoover organized important research studies on community-based child health

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<sup>19</sup> United States Children’s Bureau, *Standards of Child Welfare*, 172.

<sup>20</sup> Jocher, Katharine. “The Third White House Conference.” *Social Forces* 11, no. 4 (1933): 602-604.

<sup>21</sup> “Notes and Comments,” *Social Service Review* 3, no.3 (1929): 481-482, 481.

programs, school health services, and health education programs for Indian Boarding Schools.<sup>22</sup>

A special sub-committee on crippled children investigated the status of crippled children in the United States for the 1930 Conference. The sub-committee had over fifty members including Edgar Allen of ISCC, Harry Howett of the OCSS, who succeed Allen as President of the ISCC, Edith Reeves Solenberger, and Robert B. Osgood, a prominent orthopedic surgeon from Harvard University who would later serve as an advisor to the federal Crippled Children's Services (CCS) program.<sup>23</sup> In one of the Conference's reports, *The Handicapped Child: The Report of the Committee on Physically and Mentally Handicapped*, the sub-committee provided a detailed discussion about crippled children's programs from all over the country. The report became a widely quoted resource on crippled children during the 1930s.<sup>24</sup> The crippled children's sub-committee favored state-based programs of care for crippled children with a federal agency providing oversight and funding.<sup>25</sup> While the sub-committee stressed that such a federal program would involve the cooperation of the Federal Offices of Education and Vocational Rehabilitation, USCB, and the United States Public Health Service (USPHS), it ultimately recommended the Federal Bureau of Vocational Rehabilitation as an administrative home because the agency had established working relationships with state governments.

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<sup>22</sup> Van Ingen, Philip. "The Story of the American Child Health Association." *Child Health Bulletin* 11, no. 5 & 6 (1935): 149-188.

<sup>23</sup> Howett, Harry H. "The White House Conference Program for Crippled Children." *Hospital Social Service* 22 (1930): 121-134.

<sup>24</sup> Solenberger, Edith Reeves, "Crippled Children." In *Social Work Year Book 1933: A Description of Organized Activities in Social Work and in Related Fields*, edited by Fred Hall, 113-116. New York, NY: Russell Sage Foundation, 1933.

<sup>25</sup> White House Conference on Child Health and Protection, *The Handicapped Child*, 178.

A larger committee of 1930 Conference, the Committee on National, State and Local Organizations for the Handicapped, produced additional recommendations relevant to the care of crippled children. This committee supervised the work of six sub-committees and had thirty-one members including Ida Curry of the States Charities Aid Association in New York, Agnes K. Hanna of the Social Service Division at USCB, and Sophonisba Breckinridge of the School of Social Service Administration at the University of Chicago.<sup>26</sup> The Committee on National, State and Local Organizations for the Handicapped was one of four main committees at the conference (including the Committee on Physically and Mentally Handicapped, the Committee on Socially Handicapped-Dependency and Neglect, and the Committee on Socially Handicapped – Delinquency) investigating the needs of socially and physically handicapped children. The sub-committee on crippled children was one of six sub-committees under the main Committee on Physically and Mentally Handicapped.

In their report, the Committee on National, State and Local Organizations for the Handicapped listed recommendations for services deemed essential for all socially and physically handicapped children, including crippled children. First, state governments should be responsible for developing and maintaining child welfare programs, and within these programs, medical, educational, and social services should be provided to all crippled children living in the state.<sup>27</sup> Second, while states should have the freedom to develop their own programs, the federal government should be responsible for identifying and mandating national minimum standards of care for state programs. Financial support

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<sup>26</sup> White House Conference on Child Health and Protection. *Organization for the Care of Handicapped Children: National, State, Local*. New York, NY: The Century Company, 1932.

<sup>27</sup> White House Conference on Child Health and Protection. *Organization for the Care of Handicapped Children*, 411-412.

for state programs should come from the federal government in the form of grant-in-aid and research programs.<sup>28</sup> These recommendations reflected the development of more interdependency and cooperation between states and the federal government that occurred during the first half of the twentieth century. Specific recommendations about services for state-level programs for crippled children came from the sub-committee on crippled children. Recommended services included: 1) case finding; 2) medical screening and diagnosis; 3) medical and surgical care; 4) after care; 5) appropriate medical equipment; 6) special education in schools, hospitals and homes; 7) vocational training and placement; and 8) preventive work on the causes of crippling conditions.<sup>29</sup>

The 1930 White House Conference offered a more comprehensive approach to the care and treatment of crippled children, a reflection of the professionalization of the Progressive Era reform efforts from earlier decades. Social reformers and child health advocates from the Progressive Era considered the use of expertise and social science research as standard practice for addressing problems in infancy and childhood through policy and programs. The 1930 Conference also reflected changes in the federal government with the election of President Hoover in 1929. Unlike his predecessors Roosevelt or Wilson, Hoover emphasized the role of experts and technical solutions as a way to address the country's social problems.<sup>30</sup>

One reason for the increased visibility of crippled children at the 1930 conference was the involvement of the ISCC. Initially, conference organizers did not plan to address the needs and treatment of crippled children, but the ISCC advocated for the inclusion of

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<sup>28</sup> *Ibid.*

<sup>29</sup> *Ibid.*, 456.

<sup>30</sup> Wilson, Joan. *Herbert Hoover, Forgotten Progressive*. Boston, MA: Little, Brown and Company, 1975.

reports on the status of crippled children.<sup>31</sup> Further, the 1930 Conference simply produced more information and data on all topics related to the health and well-being of children than the other two conferences. Once published, the 1930 Conference proceedings comprised thirty different volumes compared with one or two volumes of reports from the 1909 and 1919 White House Conferences.<sup>32</sup> Two of the volumes included detailed reports related to the care and treatment of crippled children.

The progression of attention to crippled children at the first three White House Conferences offers an example of the efforts by social reformers, health care professionals, and even state-level administrators to advance services and programs for crippled children. At the 1909 Conference, children's advocates were beginning to form and develop a national conversation about the problems of childhood, including the needs of crippled children. Rather than detailed plans and recommendations, conference participants emphasized general principles about child health and welfare, and the need to know more. By the 1919 Conference, the national dialogue on crippled children focused more on program and policy development at the state-level, and by the 1930 Conference, participants offered specific recommendations for state and federal programs for crippled children. This development also reflects the increasing organization of American society through the expansion of interest groups, professions, and social science research. Efforts for crippled children became more systematic and professionalized by the 1930s, following this general development of reform efforts for children.

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<sup>31</sup> Howett, Harry H. "A Brief Summary of the 8th Annual Meeting of the International Society for Crippled Children." *The Crippled Child* 7, no. 1 (1929): 21-23; Howett, "The White House Conference Program," 125.

<sup>32</sup> Jocher, "The Third White House Conference," 602-604.

*Proceedings of the National Conference of Social Work (1874-1982)*

The first reference to crippled children at the National Conference of Social Work (NCSW) occurred at the 1877 meeting when W.P. Letchworth, Vice President of the New York Board of Charities, reported that crippled children lived in poorhouses all over the State of New York. He noted that many of the children “are of bright intellect, who, if separated from poorhouse associations, and placed under skilled medical treatment, might be restored and trained to industrial pursuits, and thus be made useful to society, and, in many places, self-supporting.”<sup>33</sup> From the beginning, it seemed that participants at the NCSW meetings considered children with physical handicaps a group worthy of attention and intervention.

Figure 1 shows the number of presentations per decade that referenced crippled children in the proceedings of NCSW from 1874 through 1939. As can be seen, the interest in crippled children rose steadily from the late nineteenth century through the first decade of the twentieth century. In the 1910s, the number of presentations declined, only to increase again during the 1920s. Despite another decline in the 1930s, interest in crippled children during the early twentieth century remained high as the number of presentations never dropped to levels seen in the late 1800s. Social work researcher Terri Combs-Orme used the same methodology to understand the contributions of the social work profession to infant mortality work during the twentieth century, but discovered a different pattern.<sup>34</sup> Her research showed a similar increase in presentations about infant mortality during the early 1900s, but then a decline in references during the 1920s and

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<sup>33</sup> Letchworth, W.P. “Report on Dependent and Delinquent Children.” In *The Proceedings of the Conference of Charities, September 1877*, 60-80. Saratoga, NY: A. Williams & Company, 1877, 71.

<sup>34</sup> Combs-Orme, Terri. “Infant Mortality and Social Work: Legacy of Success.” *The Social Service Review* 62, no. 1 (March 1988): 83-102.

1930s. Figure 2 compares the number of presentations for infant mortality and crippled children from 1900 to 1939. Combs-Orme suggested the child saving reform efforts of the early twentieth century contributed to the high levels of interest in infant mortality among social workers. Later declines in the concern for infant mortality reflected the profession's interest in social work specialization and individual casework over social reform.<sup>35</sup>

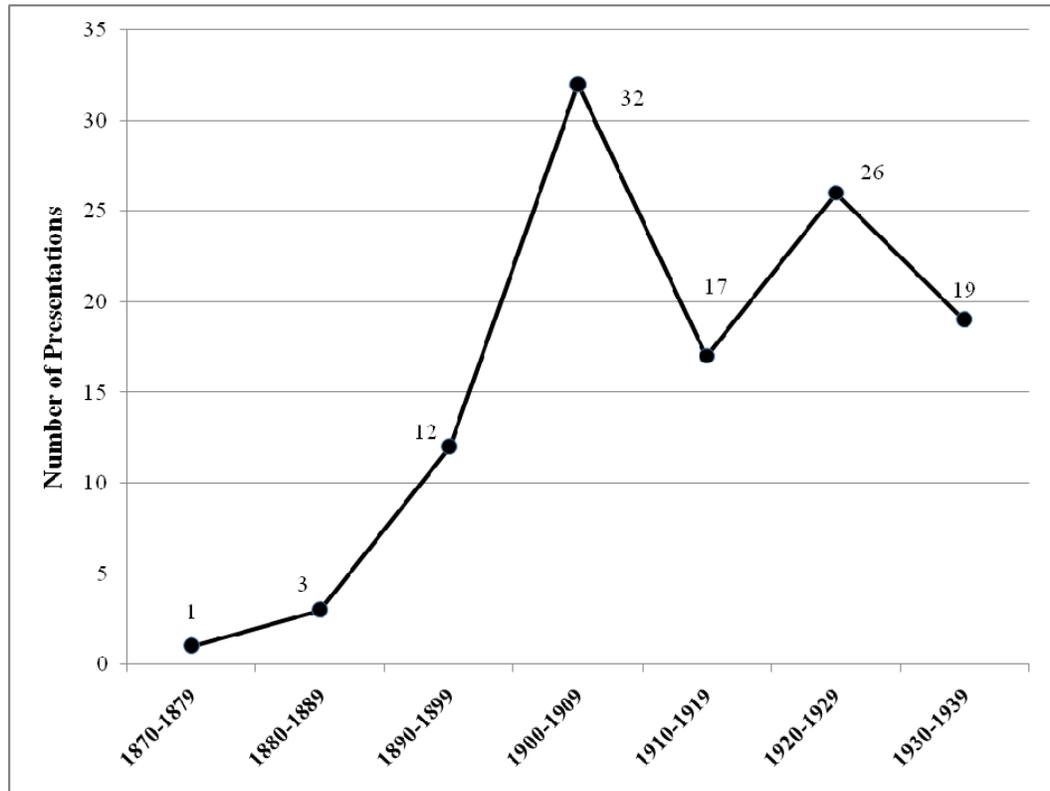
Compared to infant mortality, interest in crippled children remained relatively high in the early twentieth century. Both were important child health problems of the day, and both were included in Title V programs of the Social Security Act in 1935. However, social reformers appeared to maintain an interest in crippled children even as the interest in infant mortality declined, as manifested in the attention paid to the problem at the National Conference.

Two reasons may account for the steady increase of interest in crippled children's services at the NCSW from 1870 to 1910. First, as discussed in Chapter 2, the number of public and private institutions and other programs providing services to crippled children increased steadily from the late nineteenth century throughout the early twentieth century. Similarly, presentations about crippled children during the first decades of the NCSW focused on development of local and state-level services for crippled children. Most presenters discussed either the need to expand crippled children's services in their states or the need to improve services. Representatives from Florida, Indiana, and North Dakota all reported the lack of crippled children's hospitals in their state as a problem.<sup>36</sup>

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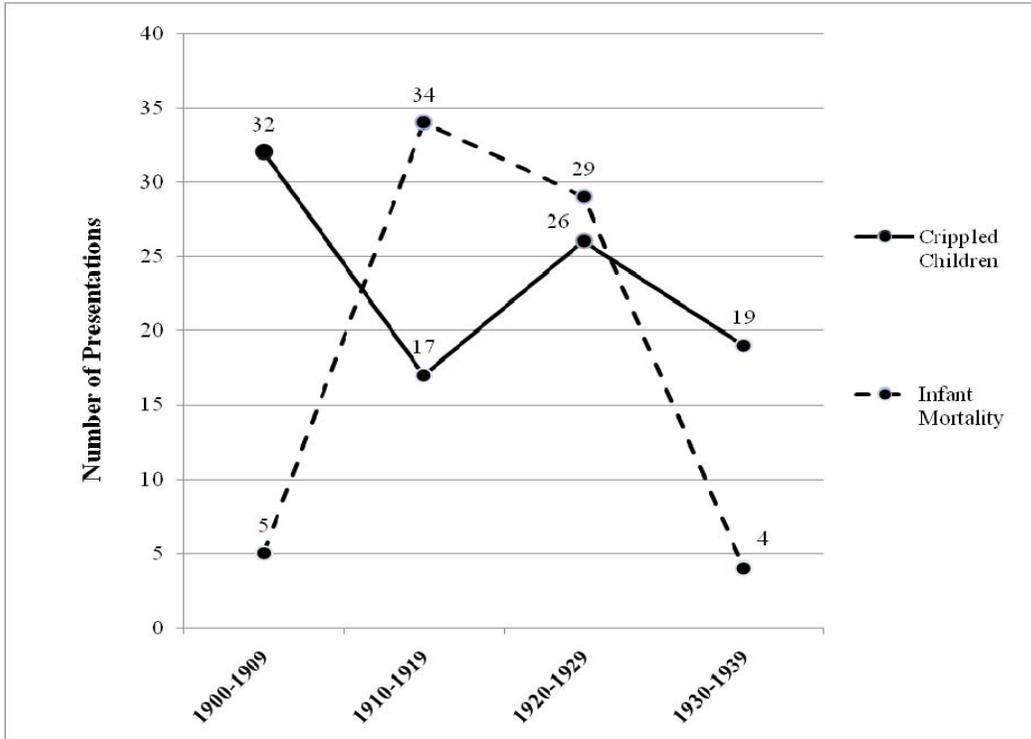
<sup>35</sup> Combs-Orme, "Infant Morality and Social Work," 93.

<sup>36</sup> Johnson, Alexander, ed. *Proceedings of the National Conference of Charities and Correction at the Thirty-fourth Annual Session held in the City of Minneapolis, Minn., June 12<sup>th</sup> to 19<sup>th</sup>*. Indianapolis, IN: Press of WM. B. Burford, 1907, 532-533, 565.



Source: "National Conference on Social Welfare Proceedings (1874-1982)," University of Michigan Digital Library, <http://quod.lib.umich.edu/n/ncosw/>.

Fig. 1. References to crippled children in the proceedings of the National Conference of Social Work, 1874-1939.



Source: Combs-Orme, "Infant Morality and Social Work," 85; "National Conference on Social Welfare Proceedings (1874-1982)," University of Michigan Digital Library, <http://quod.lib.umich.edu/n/ncosw/>.

Fig.2. References to crippled children and infant mortality in the proceedings of the National Conference of Social Work, 1900-1939.\*

\*Data on infant mortality only available starting in 1900.

Unlike other areas of child health and welfare, institutions such as hospitals and convalescent homes were considered essential to the treatment of crippled children at the time.<sup>37</sup>

Second, the child saving movement in the United States during the late nineteenth and early twentieth centuries increased public awareness about all problems associated with childhood including infant mortality, child labor, and juvenile delinquency. Child savers and social reformers believed that public programs and policies were necessary to address the ills of society that negatively affected children and their families. Michael Katz argued the most successful and popular child saving efforts were those connected with the fields of public health and medicine, of which the movement to improve the lives of crippled children was one. Reasons for the success of public health efforts in improving the lives of children included: 1) easy to understand goals of reducing death and disability; 2) a scientific base for inventions in medicine and germ theory; 3) local authority and funding sources for the programs; and 4) interventions that were not class-specific.<sup>38</sup> State and local crippled children's programs that developed during this time typically met these criteria. These programs sought to correct disabling or deforming conditions among children through medical treatment, appropriate after care services, and preventive efforts. Further, programs for crippled children developed at local and state-levels before the federal level in the United State, drawing on revenue from private donations and local appropriations. Lastly, crippling diseases and deformities affected children from all social classes, and early programs, such as those operated by the

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<sup>37</sup> Reeves, *Care and Education of Crippled Children*, 2.

<sup>38</sup> Katz, Michael B, *In the Shadow of the Poorhouse: A Social History of Welfare in America*. New York, NY, Basic Books, 1996, 147.

Association for the Aid of Crippled Children (AACC) in New York, provided services for children from both wealthy and poor families.<sup>39</sup>

Starting in 1910, interest in crippled children at the NCSW appeared to vacillate for the next few decades. From 1910 to 1919, presentations related to crippled children declined at the conference. However, several presenters continued to discuss the need to develop and expand state services for crippled children. In 1912, one presenter stated that quality professional care for crippled children “is beyond the resource and skill of small communities and appeals very strongly to the broadening vision of duty opening before an improving civilization.”<sup>40</sup> This viewpoint was very consistent with Progressive Era reformers who considered rural communities lacking in the ability to develop social welfare programs on their own. As a result, social welfare programs, including services to crippled children, tended to develop and expand in urban communities.<sup>41</sup>

Additionally, social work professionals began stressing the importance of collaboration among different child health and education programs in the design and implementation of crippled children’s programs. In 1912, Ida M. Cannon, a leading expert in medical social work, described how collaboration between a hospital social service department and a local school board created a hospital-based school for crippled

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<sup>39</sup> Association for the Aid of Crippled Children, *Annual Reports*, 1909-1996, Reels 32, 33, and 34, Foundation for Child Development, Microfilm Collection, RAC.

<sup>40</sup> Kingsley, Sherman C, “Community Recognition of Children's Rights and Needs,” In *Proceedings of the National Conference of Charities and Corrections at the 39th Annual Session Held in Cleveland, Ohio, June 12-19, 1912*, edited by Alexander Johnson, 20-25, Fort Wayne, IN: Fort Wayne Printing Company, 1912, 24.

<sup>41</sup> Stuart, Paul H. “Social Welfare and Rural People: From the Colonial Era to the Present.” In *Rural Social Work: Building and Sustaining Community Assets*, edited by T. Line Scales and Calvin L. Streeter, 21-33. Brooks/Cole/Thomson Learning, 2003, 26-27.

children.<sup>42</sup> Other presentations depicted similar collaborative efforts in Iowa, New York and Minnesota between crippled children's programs and local school districts to improve educational and vocational rehabilitation services for crippled children.<sup>43</sup>

The quantity and type of presentations about crippled children during this decade may reflect a larger trend among state-level child welfare programs of the time – the development of Children's Codes. First proposed at the 1910 National Conference by Judge George Addams, a juvenile court justice from Cleveland, Ohio, Children's Codes offered a way for state governments to categorize all their different laws and regulations relating to children into one code, eliminating conflicts within the laws and mandating cooperation between state agencies.<sup>44</sup> In his presentation, Addams stated that “a judge can commit to a State institution a child suffering from physical defects, but neither he nor any other power can compel the institution to receive it.”<sup>45</sup> But supporters considered the Children's Code more than an administrative tool to improve efficiency within state governments.<sup>46</sup> It provided a means improve the quality of health, education, and happiness for all American children, including crippled children. State governments quickly adopted the idea, and by 1923, twenty-nine had developed commissions tasked to

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<sup>42</sup> Cannon, Ida M, “On Hospital Social Services,” In *Proceedings of the National Conference of Charities and Corrections at the 39th Annual Session Held in Cleveland, Ohio, June 12-19, 1912*, edited by Alexander Johnson, 335-339, Fort Wayne, IN: Fort Wayne Printing Company, 1912.

<sup>43</sup> Adams, Matthew P, “The Schools of Children's Societies as Experiment Stations,” In *Proceedings of the National Conference of Charities and Corrections at the 43rd Annual Session Held in Indianapolis, Indiana, May 10-17, 1916*, 568-577, Chicago, IL: The Hildman Printing Co., 1916; Brakett, Jeffery R, “Public Outdoor Relief in the United States,” In *Proceedings of the National Conference of Charities and Corrections at the 42nd Annual Session Held in Baltimore, MD, May 12-19, 1915*, 446-457, Chicago, IL: The Hildman Printing Co., 1915; Sessions, FJ, “Vocational Training in Institutions,” In *Proceedings of the National Conference of Charities and Corrections at the 40th Annual Session Held in Seattle, Washington, July 5-12, 1913*, 287-292, Fort Wayne, IN: Fort Wayne Printing Company, 1913.

<sup>44</sup> Clopper, Edward N. “The Development of the Children's Code.” *Annals of the American Academy of Political and Social Science* 98 (1921): 154-159.

<sup>45</sup> Addams, George S, “Report on the Committee of Children,” In *The Proceedings of the National Conference of Charities and Corrections at the 37th Annual Session Held in St. Louis, Mo., May 19th to 26th 1910*, edited by Alexander Johnson, 88-90, Fort Wayne, IN: The Archer Printing Company, 1910, 88.

<sup>46</sup> Clopper, “The Development of the Children's Code,” 154.

create Children's Codes in their states. Recommended legislation to be included in Children's Codes included eugenics, infant welfare, neglected and delinquent children, public and private institutions for children, and educational programs. Many states such as Oregon, Connecticut, Ohio, and Georgia included regulations pertaining to crippled children's services in their codes.<sup>47</sup>

The 1920s saw an increased interest in crippled children. This coincided with an increase in the number of state-level facilities for crippled children reported in 1924 by the ISCC.<sup>48</sup> Discussions at the NCSW now included ways to improve treatment models and programs for crippled children. New best practices for crippled children stressed the importance of non-institutional care and the inclusion of educational services.<sup>49</sup> Several presentations at the National Conference described work for crippled children by fraternal organizations and private charities. Participants also began discussing the role and responsibilities of professionals working with crippled children. In 1921, hospital social work pioneer Ida M. Cannon asserted that social workers were uniquely qualified to ensure that crippled children leaving the hospital following surgical and orthopedic treatment had the proper community referrals and arrangements for after care services.<sup>50</sup> Several national leaders in child health such as Grace Abbott, Harry Howett, and Edith Reeves Solenberger promoted the continued expansion of services to ensure care for all crippled children in the United States. In 1927, Abbott also stated that more needed to be

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<sup>47</sup> Lundberg, Emma Octavia, *State Commissions for the Study and Revision of Child-Welfare Laws*. Washington, DC: Government Printing Office, 1924.

<sup>48</sup> See Chapter 2 for detailed discussion of institutions prior to 1935. Abt, *The Care, Cure, and Education*, 70-71.

<sup>49</sup> Solenberger, Edith Reeves, "The Extension of Non-Institutional Care for Crippled Children," In *The Proceedings of the National Conference of Social Work at the 48th Annual Session Held in Milwaukee, Wisconsin, June 22-29, 1921*, 105-108, Chicago, IL: The University of Chicago Press, 1921.

<sup>50</sup> Cannon, Ida M, "The Relation of Hospital Social Service to Child Health Work," In *Proceedings of the National Conference of Social Work at the 48th Annual Session Held in Milwaukee, Wisconsin, June 22-29, 1921*, 179-181, Chicago, IL: The University of Chicago Press, 1921.

done to improve the health and well-being of rural children, including those suffering from physical handicaps.<sup>51</sup>

In her 1928 USCB report, Solenberger offered several reasons for the increased attention to crippled children's services during the 1920s.<sup>52</sup> First, a general expansion of federal public health programs had occurred in the United States. The passage of the Sheppard-Towner Act (STA) in 1921 created state-level infrastructure for maternal and child health (MCH) services while providing preventive health care to millions of women and children.<sup>53</sup> Designed to reduce infant and maternal mortality, the STA was passed by Congress, in part, due to the strong support of organized women's groups throughout the nation and the legislative efforts of Julia Lathrop and Grace Abbott of the USCB, and Jeanette Rankin, the first woman and first social worker elected to Congress in 1917.<sup>54</sup> The Act provided approximately \$1 million dollars (\$75 million in 2008 dollars) in annual federal funding and states were required to match federal appropriations dollar-for-dollar.<sup>55</sup> The USCB monitored the development of state-level programs and provided technical assistance as needed. By 1925, forty-five states and territories established 561 infant and maternity centers, provided almost 300,000 home nursing visits to pregnant

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<sup>51</sup> Abbott, Grace, "Developing Standards of Rural Child Welfare," In *Proceedings of the National Conference of Social Work at the 54th Annual Session Held in Des Moines, Iowa, May 11-18, 1927*, 26-36, Chicago, IL: The University of Chicago Press, 1927.

<sup>52</sup> Solenberger, *Crippled Children with Special Reference*, 1.

<sup>53</sup> Lemons, J. Stanley. "The Sheppard-Towner Act: Progressivism in the 1920s." *The Journal of American History* 55, no. 4 (1969): 776-786; Skocpol, Theda. *Protecting Soldiers and Mothers: The Political Origins of social policy in the United States*. The Belknap Press of Harvard University Press: Cambridge, MA, 1992.

<sup>54</sup> Lindenmeyer, *A Right to Childhood*, 86-90; Smith, Norma. *Jeanette Rankin, America's Conscience*. Helena, MO: Montana Historical Society Press, 2002.

<sup>55</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy, The Administration of the Act of Congress of November 23, 1921, Fiscal year ended June 30, 1929*. Publication No. 203. Washington, DC: Government Printing Office, 1931, 2-3.

women and infant, and held over 21,000 child health conferences.<sup>56</sup> Although Congress eliminated funding for the Act in 1929, it offered Progressive Era reformers a powerful example of how the health care needs of women and children could be addressed by the federal government.

Similarly, the Vocational Rehabilitation Act of 1918 and the Civilian Vocational Rehabilitation Act of 1920 expanded services for disabled veterans from World War I and industrial workers injured on the job. These laws established state-level medical and educational services for disabled adults and adolescents transitioning to employment.<sup>57</sup> By 1923, thirty-six states operated vocational rehabilitation programs with \$1.1 million dollars (\$67 million in 2008 dollars) in federal and state-matched funding.<sup>58</sup> During the 1920s, these state programs served an annual average of 4,300 disabled adults.<sup>59</sup> While not specifically designed for children, these vocational rehabilitation programs increased public awareness about all individuals with physical handicaps.

Second, the United States experienced a large growth in philanthropic work on behalf of crippled children by private individuals and organizations such as fraternal orders, service groups, and charities. One expert suggested that crippled children's programs had more volunteer activity than any other child health and welfare program.<sup>60</sup>

Fraternal orders such the Shriners and the Elks established facilities and services for

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<sup>56</sup> Meckel, Richard A. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*. Ann Arbor, MI: Ann Arbor Paperbacks, 1998, 212; United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy*, 1.

<sup>57</sup> Cahn, Reuben D. "Civilian Vocational Rehabilitation." *The Journal of Political Economy* 32, no. 6 (1924): 665-689; Holt, William Stull, *The Federal Board for Vocational Education: Its History, Activities and Organization*. D. Appleton and Company: New York, NY, 1922; Obermann, Carl E. *A History of Vocational Rehabilitation in America*. New York, NY: Ayer Publishing, 1980.

<sup>58</sup> Obermann, *A History of Vocational Rehabilitation*, 246-247; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>59</sup> United States Department of Health, Education, and Welfare. *Statistical History: Federal-State Program of Vocational Rehabilitation, 1920-1969*. Washington, DC: Government Printing Office, 1970, 6.

<sup>60</sup> White House Conference on Child Health and Protection. *Preliminary Committee Reports*. New York: The Century Company, 1930, 452.

crippled children beginning in the 1920s. Women's groups such as the state affiliates of the General Federation of Women's Clubs and the Junior League sponsored local orthopedic clinics for crippled children.<sup>61</sup> The leading proponent of increased support for crippled children's programs was the ISCC, established in 1919. The Society advocated for government-sponsored services and, in the early 1930s, for federal legislation to expand the services to crippled children within the Federal Office of Education (FOE). By 1928, the ISCC sponsored affiliate societies in twenty-five states and Canada, published a bi-monthly journal, and organized an annual national conference of state affiliates. In 1929, the Society sponsored one of the first international conferences on needs of crippled children in Geneva, Switzerland.

A third reason for increased attention to crippled children cited by Solenberger was the first major polio epidemic in the United States in 1916. The epidemic resulted in over 27,000 cases of polio and 6,000 deaths that year.<sup>62</sup> Of those children that survived the first weeks of the disease, more than half required lengthy, intensive treatment to prevent permanent disfigurement.<sup>63</sup> State agencies responded to the crisis by developing emergency community-based services for children crippled by the disease. In her research on the development of crippled children's services in Virginia during the early twentieth century, Mary Gibson suggested that the causes of crippling conditions among

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<sup>61</sup> "Here and There---General Federation of Women's Clubs," *The Crippled Child* 11 no. 5 (1934): 107, Folder ICSS – The Crippled Child, Box 38, Pamphlet and Newsletter Collection, Social Welfare History Archives, Minneapolis, MN (hereafter SWHA); The Alabama Society for Crippled Children, "Annual Report of the Alabama Society for Crippled Children," 1929, Folder 65, Box SG006938, Public Information General Files, ADAH; Greene, Mrs. Charles W. "The Work of the Missouri State Federation of Women's Clubs with Crippled Children." *The Crippled Child* 7, no. 5 (1930): 135-136.

<sup>62</sup> New York State Department of Health. *Thirty-Seventh Annual Report of the State Department of Health, Vol. 1*. New York, NY: New York State Department of Health, 1917, 402.

<sup>63</sup> Gould, Tony, *A Summer Plague: Polio and Its Survivors*. New Haven; London: Yale University Press, 1997; "Conference of Infantile Paralysis," 1916, 6, Folder 283, Box 25, Series 200, RG 1.1, Rockefeller Foundation Archives, RAC.

children influenced the development of programs, policies and services. She asserted that efforts to treat TB among children influenced the development of crippled children's programs in the late nineteenth century while polio affected the funding and growth of services in the twentieth century.<sup>64</sup>

National interest in crippled children waned in the early 1930s as social reformers, politicians, and private citizens dealt with the economic and social effects of the Great Depression. From 1930 to 1934, only five presentations at the NCSW mentioned programs or efforts related to crippled children. But 1935 marked a dramatic change due to the establishment of the long-awaited federal crippled children's program. Social work professionals and child welfare advocates attending the conferences now focused on learning about the new federal program and expanding state-level services to crippled children. Of the thirteen presentations related to crippled children from 1935 to 1939, USCB leaders presented three of them. In 1937, both Katherine Lenroot, chief of the Bureau, and Robert C. Hood, director of the Crippled Children's Division, reviewed the new federal CCS program, outlining state requirements and the types of medical care to be offered under the program.<sup>65</sup> Martha May Elliot spoke at the 1939 conference about how the federal CCS program corresponded with other federal child health and

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<sup>64</sup>Gibson, Mary Eckenrode. "From Charity to An Able Body: The Care and Treatment of Disabled Children in Virginia, 1910--1935." PhD dissertation, University of Pennsylvania, 2007; Gibson, Mary E. "Two Surges of Care for Crippled Children: The Framing of Disease Conditions and Influences on Development of Care 1900-1935," presented at the *Tenth Annual Meeting of Southern Association for the History of Medicine and Science*, University of Florida, Gainesville, FL, 2008 dollars.

<sup>65</sup> Hood, R.C., "Medical Care for Crippled Children," In *Proceedings of the National Conference of Social Work at the 64th Annual Session Held in Indianapolis, Indiana, May 23-29, 1937*, 542-548, Chicago, IL: The University of Chicago Press, 1937; Lenroot, Katharine F., "The Federal Government and Desirable Standards of State and Local Administration," In *Proceedings of the National Conference of Social Work at the 64th Annual Session Held in Indianapolis, IN, May 23-29, 1937*, 432-43, Chicago, IL: The University of Chicago Press, 1937.

welfare programs.<sup>66</sup> Eliot also discussed the need for trained professionals to work in the new federal program and educating the public about the new program.

Despite the decline in presentations during the 1930s, interest in crippled children among conference participants was higher than for infant mortality (see Figure 2). One possible reason was that work with crippled children provided more opportunities for social workers during this time than programs to reduce infant mortality. While social workers played an important role in the creation and administration of the STA during the 1920s, the Act supported the expansion of public health nursing more than medical social work at local and state-level health departments and MCH programs.<sup>67</sup> During the 1920s, medical social workers were mostly employed in hospitals and outpatient clinics, but would later expand their services to state health and relief programs during the 1930s.<sup>68</sup> Medical social work developed from hospitals and outpatient medical clinics, starting in the early 1900s, where social workers would have helped crippled children receiving orthopedic and medical treatments. As services for crippled children grew during the early twentieth century, social work was recognized as an essential profession in the care and treatment of crippled children. Types of services provided by social workers to crippled children included case finding, intake and eligibility services and

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<sup>66</sup> Eliot, Martha M, "The Work of the Interdepartmental Committee to Coordinate Health and Welfare Activities," In *The Proceedings of the National Conference of Social Work at the 66th Annual Session Held in Buffalo, NY, June 18-24, 1939*, 101-110, Chicago, IL: The University of Chicago Press, 1939.

<sup>67</sup> Fitzpatrick, M. Louise. *The National Organization for Public Health Nursing, 1912-1952: Development of a Practice Field*. New York, NY: National League for Nursing, 1975, 84-85; United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy, The Administration of the Act of Congress of November 23, 1921, Fiscal year ended June 30, 1929*. Publication No. 203. Washington DC: Government Printing Office, 1931, 12-13.

<sup>68</sup> "Association Interests in Related Fields," *Bulletin of the American Association of Medical Social Workers* 6 no. 8 (1933): 81-88, Folder 1930-33, Box 3, American Association of Medical Social Workers, Pamphlet and Newsletter Collection, SWHA; Kerson, Toba Schwaber. "The Pre-Professional Paradox: A Study in the Sociology of the Professions." Ph.D., University of Pennsylvania, 1978, 71; Stites, Mary A. *History of the American Association of Medical Social Workers*, 25-28.

provisions for after care services.<sup>69</sup> With the passage of the SSA in 1935, social workers also found roles in state-level CCS programs as policy developers, administrators, and consultants.<sup>70</sup>

### Conclusion

Like other child saving reform efforts of the early twentieth century, several factors contributed to raising the awareness about crippled children from state-level programs to the national reform agenda. These included the 1916 polio epidemic, the growth of state-level programs for crippled children, increased volunteer activity (especially through the work sponsored by the ISCC), and the expansion of federal public health programs during the 1920s. As local and state governments developed services for crippled children in response to demand for services (such as the 1916 polio epidemic or the growth in volunteer activity on behalf of crippled children), state leaders uncovered the extent and depth of the needs of crippled children through research and data collection. Additionally, the professionalization of orthopedics, social work, nursing, and other health-related professions resulted in the improved medical and social care for crippled children. State administrators, professionals, and social reformers alike called for federal funding and coordination to improve services for crippled children. By the 1930s, the country was poised to develop a national program of care for crippled children.

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<sup>69</sup> Tartakoff, Ruth. "Social Aspects of Medical Care for Crippled Children." *Bulletin of the American Association of Medical Social Workers* 11, no. 3 (1938): 31-40.

<sup>70</sup> Hall, Beatrice. "The Role of Medical-Social Service in the Public-Health Program." *The Child* 9, no. 8 (1945): 127-130.

## CHAPTER 4

### LEGISLATION FOR A NATIONAL CRIPPLED CHILDREN'S SERVICES PROGRAM

*"And so the crippled children's program was born."*

Martha May Eliot, Former Chief of the United States Children's Bureau  
June 22, 1966<sup>1</sup>

At the 1929 annual meeting of the International Society of Crippled Children (ISCC), conference participants such as Edgar "Daddy" Allen, Harry Howett, and Edith Reeves Solenberger highlighted the important work being done by state-level public and private agencies on behalf of crippled children. Sixteen state affiliate societies of the ISCC presented information about the status of crippled children in their states. Other presentations focused on how to expand state-level organizations, develop relations with state medical societies, and improve local fund raising efforts.<sup>2</sup> But it was Dr. Charles A. Prosser, director of the William Hood Dunwoody Industrial Institute in Minnesota, who provided a vision for a national program of services for crippled children when he asked conference participants to consider:

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<sup>1</sup> Corning, Peter. *Transcript of Oral History, Martha Eliot*. New York, NY: Oral History Research Office, Columbia University, 1969, 48.

<sup>2</sup> "Proceedings of Eighth Annual Convention: The International Society for Crippled Children, Minneapolis, 1929," Folder ICSS [Mpls], Box 38, Pamphlet and Newsletter Collection, SWHA.

...the steps that need to be taken in the social readjustment of a crippled child and the second with the spread of these steps, these services, so as to reach and adjust as far as possible every crippled child in every State of the Union.<sup>3</sup>

At the end of the conference, ISCC members resolved to expand services for crippled children to every state in the country through advocacy and legislative efforts.<sup>4</sup>

Given that efforts to improve the health and well-being of crippled children had been underway in the United States since the late 1800s, the question might rise why a federal program was not created sooner than 1935. Many considered crippled children a worthy and important group of children needing government services and protection. Advancements in the treatment of tuberculosis (TB) and polio improved medical outcomes for crippled children and a variety of ancillary services such as educational and after care programs had been developed making a holistic approach to care possible. State and local governments passed a variety of laws to support crippled children's programs. While these and other developments improved the services available to crippled children during the early twentieth century, other conditions were required to achieve a federal Crippled Children's Services (CCS) program in 1935.

#### Why not before 1935?

Social reformers and child health advocates had sought federal action on behalf of crippled children prior to 1935, but without much success. Reports from the 1930 White House Conference on Child Health Protection recommended the development of a

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<sup>3</sup> "Proceedings of Eighth Annual Convention: The International Society for Crippled Children, Minneapolis, 1929," 22, Folder ICSS [Mpls], Box 38, Pamphlet and Newsletter Collection, SWHA.

<sup>4</sup> "Proceedings of Eighth Annual Convention: The International Society for Crippled Children, Minneapolis, 1929," 140, Folder ICSS [Mpls], Box 38, Pamphlet and Newsletter Collection, SWHA.

federal program of grants and research for services for crippled children. Experts from the 1930 Conference believed a federal program would expand services for crippled children to all states and enhance the quality and types of services already provided by state and local programs.<sup>5</sup> An attempt was made in 1931 to expand the federal vocational rehabilitation program operated by the Federal Office of Education (FOE) to provide medical and educational services to crippled children, but without success.<sup>6</sup> Some state-level vocational rehabilitation and educational programs during this time did provide services to crippled children, but the FOE's vocational rehabilitation program did not provide federal appropriations to support these services. While state administrators and child health advocates called for the federal government to support services for crippled children, the political and conditions within the federal government were not ideal until 1935.

Several reasons suggest why the federal government did not develop a program of services for crippled children prior to the Social Security Act (SSA). First, while some politicians did favor federal support for health and social welfare programs, many believed that the federal government had no business sponsoring these programs. This was viewed as a responsibility of state and local governments, not the federal government. The United States has long operated under a system of federalism where political power and responsibility was separated between the different levels of government. During the nineteenth century, there was a distinguishable difference in the authority between the states and federal government. Referred to as "dual federalism,"

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<sup>5</sup> White House Conference on Child Health and Protection. *The Handicapped Child: Report of the Committee on Physically and Mentally Handicapped*. New York, NY: The Century Company, 1933, 178.

<sup>6</sup> US Senate Committee on Education and Labor. *Rehabilitation and Vocational Education of Crippled Persons: Hearing before the Committee on Education and Labor on S. 6227, 71<sup>st</sup> Cong., 3<sup>rd</sup> sess., 1931.*

most lawmakers believed that the United States Constitution specified areas in which states and the federal government were empowered to act. State governments assumed responsibility for most social policy in the country, including child health and welfare programs, while the federal government attended to such issues as foreign affairs, interstate commerce and relations with Native Americans.<sup>7</sup>

The lines of “dual federalism” began to blur as early as 1862 when Congress enacted the first Morrill Act that provided public lands to states for the development of land grant colleges. Over the next fifty years, other federal land grants supported the development of agricultural extension programs (Hatch Act of 1887), and agricultural colleges for African Americans (the second Morrill Act of 1890). By the early twentieth century, the federal government had established a series of grant-in-aid programs.<sup>8</sup> These programs helped to create roads and highways (Federal Aid Road Act of 1916 and the Federal Highway Act of 1921), an agriculture extension service (Smith-Lever Act of 1914), vocational rehabilitation services for adults (Smith-Hughes Act of 1917), health education programs for sexually transmitted diseases (Chamberlain-Kahn Act of 1918), and preventive health services for infants and mothers (Sheppard-Towner Act of 1921). Some of these early grant-in-aid programs did not last and others did. The Chamberlain-Kahn Act funding ended after only two years and the Congress stopped funding the Sheppard-Towner Act (STA) in 1929.<sup>9</sup> However, these laws laid the ground work for

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<sup>7</sup> Linhorst D. M. “Federalism and Social Justice: Implications for Social Work.” *Social Work* 47, no. 3 (2002): 201-208.

<sup>8</sup> Grodzins, Morton, and Daniel Judah Elazar, *The American System: A New View of Government in the United States*. Piscataway, NJ: Transition Publishers, 1984.

<sup>9</sup> Fairchild, Amy L, “The Democratization of Privacy: Public-Health Surveillance and Changing Conceptions of Privacy in Twentieth-Century America,” In *History and Health Policy in the United States*, edited by Rosemary Stevens, Charles E. Rosenberg, and Lawton R. Burns, 111-126, New Brunswick, NJ: Rutgers University Press, 2006; Lemons, J. Stanley. “The Sheppard-Towner Act: Progressivism in the 1920s.” *The Journal of American History* 55, no. 4 (March 1969): 776-786.

New Deal reformers to develop new intergovernmental relationships between the federal government and states during the 1930s, which became known as “cooperative federalism.”<sup>10</sup> Under this new relationship, states and the federal government worked together administratively and financially to achieve the goals of new social welfare programs. Federal regulations governing how federal monies could be applied for and used shifted power and authority for social welfare programs away from state governments to the federal government. It took the permanent funding sources of the Social Security Act (SSA) in 1935 to secure federal support for important social welfare and public health programs and to help institutionalize “cooperative federalism” within the structure of the American government.<sup>11</sup>

Another reason why a national crippled children’s program was not developed before 1935 can be found in the early work of the United States Children’s Bureau (USCB). For many years following its creation in 1912, the Bureau was the only federal agency committed to addressing all the needs of American child, referred to as the “whole child” philosophy. During that time, the USCB leadership effectively raised national awareness about problems related to children, and developed and promoted a variety of social welfare programs designed to address these problems.<sup>12</sup> Initially, the Bureau was tasked to “investigate the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of

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<sup>10</sup> Grodzins and Elazar, *The American System*, 41-43; Laslovich, Michael J. “The American Tradition: Federalism in the United States,” In *Comparative Federalism and Federation: Competing Traditions and Future*, edited by Michael Burgess and Alain Gagnon, 187-202, Toronto: University of Toronto Press, 1993.

<sup>11</sup> Patterson, James T. *The New Deal and the States: Federalism in Transition*. Princeton, NJ: Princeton University Press, 1969.

<sup>12</sup> Lindenmeyer, Kriste. *A Right to Childhood: The US Children's Bureau and Child Welfare, 1912-1946*. Urbana, IL: University of Illinois Press, 1997, 4-7.

children, employment, legislation affecting children in the several States and Territories.”<sup>13</sup>

Julia Lathrop, the first Chief of the Bureau, recognized the importance of public health programs as a means to improve the lives of American children.<sup>14</sup> The phrase “accidents and diseases of children” would have allowed Lathrop to select the needs of crippled children for the Bureau’s first project, but instead she chose infant mortality. Lathrop opted for infant mortality because it was a problem largely ignored by the medical community and other federal agencies, such as the United States Public Health Service (USPHS), thus enabling the Bureau to safely avoid service duplication and professional turf issues.<sup>15</sup> In contrast, orthopedic surgeons and other medical practitioners were heavily invested in the care and treatment of crippled children, and many states had already established state-level programs for crippled children. Additionally, Lathrop had been a resident of Hull House and knew many in the Settlement House Movement including Lillian Wald, Jane Addams and Florence Kelley. All of these reformers were very familiar with the effects of infant mortality on families and communities. They strongly supported Lathrop’s decision to focus Bureau efforts on preventing infant deaths. Early support for crippled children’s programs came primarily from private voluntary groups and fraternal orders, which were less involved with the work of the USCB, not from the settlements.

With the prevention of infant mortality as its initial focus, the USCB began a series of research studies that dominated the Bureau’s work for years. From 1912 to 1922, the Bureau conducted nine investigations of infant mortality, supported the creation

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<sup>13</sup> United States Children's Bureau. *The Establishment of the Children's Bureau*. Washington DC: Government Printing Office, 1912, 1.

<sup>14</sup> Parker, Jacqueline K., and Edward M. Carpenter. “Julia Lathrop and the Children's Bureau: The Emergence of an Institution.” *The Social Service Review* 55, no. 1 (March 1981): 60-77.

<sup>15</sup> Parker and Carpenter, “Julia Lathrop and the Children’s Bureau,” 64-65.

of a national birth registry, and administered the STA during the 1920s.<sup>16</sup> Scholars credit the work of the USCB as an important factor in the reduction of infant deaths during the early twentieth century.<sup>17</sup> However, efforts to reduce crippling conditions among children continued to receive little attention during the first ten years of the Bureau's existence. During this time, the USCB carried out no investigations relevant to the needs of crippled children. It was not until the mid-1920s that the Bureau staff initiated two different studies related to crippled children; one on rickets in 1923 and another on state-level programs for crippled children in 1925.<sup>18</sup> By the end of the 1920s, the Bureau began providing consultation services to state-level crippled children's program, but no funds were available to support other types of programs for crippled children.<sup>19</sup> As the funding for the STA ended in 1929, concluding one of the Bureau's most successful infant mortality prevention programs, the United States also entered the one of the most serious economic depression of the century.

The Great Depression created extremely difficult social and economic conditions in the United States. By 1933, almost fifteen million Americans were out of work, and many lacked personal financial resources to meet the basic needs of their families.<sup>20</sup> As a result, more than one million families were enrolled in relief programs throughout the

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<sup>16</sup> "Annotated List of Published Studies, Children's Bureau, 1912-1951," Letter A-1, Part 3, Reel 66, The Records of the Children's Bureau, 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

<sup>17</sup> Almgren, Gunnar, Susan P. Kemp, and Alison Eisinger. "The Legacy of Hull House and the Children's Bureau in the American Mortality Transition." *Social Service Review* 74, no. 1 (March 1, 2000): 1-27. Meckel, Richard A. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*. Ann Arbor, MI: Ann Arbor Paperbacks, 1998, 24.

<sup>18</sup> Eliot, Martha M., "The Control of Rickets: Preliminary Discussion of the Demonstration in New Haven," *The Journal of the American Medical Association* 85(1925): 656-661; United States Children's Bureau. *Thirteenth Annual Report of the Chief of the Children's Bureau*. Washington DC: Government Printing Office, 1925, 5-6.

<sup>19</sup> Abbott to Chase, December 16, 1929, File 7-5-4, Box 408, Records of the Children's Bureau, RG 102, NARA.

<sup>20</sup> Patterson, *The New Deal and the States*, 26.

country.<sup>21</sup> Numerous studies by the USCB and the USPHS found poor health conditions among most Americans, especially children, caused by poverty and lack of access to food and clean water. Health care experts considered malnutrition among children to be the most devastating health problem in the country. Studies showed that forty percent of children surveyed suffered from malnutrition, and that rates of rickets among children were on the rise.<sup>22</sup> One nursing agency in Philadelphia reported that “individuals formerly able to afford private physicians are now bringing their children to our child health conferences.”<sup>23</sup> Additionally, a study of transient children in 1932 found that over fourteen hundred boys and adolescents under the age of 21 experienced accidents along the railroad lines that resulted in the loss of limbs or disfigurement, an eighty percent increase from 1929.<sup>24</sup>

Social reformers, concerned about the decline in health among American children, spoke out about the need for federal relief efforts to address the harmful effects of the Depression on children, including crippled children.<sup>25</sup> In a 1933 article in the *New York Times*, Grace Abbott warned “that it should be a first charge of our resources to tip the scales in favor of health for these children.”<sup>26</sup> The USCB organized the Child Health Recovery Conference in October 1933, hoping the conference would re-new interest among state governments and private agencies to fund child health programs in their

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<sup>21</sup> United States Children's Bureau. *Twentieth Annual Report of the Chief of the Children's Bureau*. Washington, DC: Government Printing Office, 1932, 3.

<sup>22</sup> Abbott, Grace. “Child Health Recovery.” *The Survey* 69, no. 10 (1933): 349-350; Abbott, Grace. *From Relief to Social Security: The Development of the New Public Welfare*. Chicago, IL: The University of Chicago Press, 1941; Sydenstricker, Edgar. “Health and the Depression.” *The Milbank Memorial Fund Quarterly Bulletin* 11, no. 4 (1933): 273-280.

<sup>23</sup> Benjamin, Paul L. “The Family Society and the Depression.” *The Annals of the American Academy of Political and Social Science* 160, no. 1 (1932): 135-143, 141.

<sup>24</sup> Abbott, Grace. *From Relief to Social Security: The Development of the New Public Welfare*. Chicago, IL: The University of Chicago Press, 1941, 53; United States Children's Bureau. *Twentieth Annual Report*, 5-8.

<sup>25</sup> Clarke A. Chambers, *Seedtime of Reform: American Social Service and Social Action, 1918-1933*. Ann Arbor, MI: The University of Michigan Press, 1967.

<sup>26</sup> Grace Abbott, “Children of Unemployed Face Hardships,” *The New York Times*, November 26, 1933.

states. Many states had eliminated state-level child health and hygiene programs that developed under the STA funding in the 1920s. Later, the Federal Emergency Relief Administration authorized funds to provide school lunches and medical care for malnourished children, and to hire nurses to staff child health clinics sponsored by state health departments.<sup>27</sup> During this time, the ISCC advocated for a federal vocational rehabilitation program for children and adolescents with physical handicaps. Edgar Allen testified before Senate Committee on Education and Labor in 1931 “that 90 per cent of the crippled children that we [ISCC] run across are unable to help themselves through their families...they lack the price of care.”<sup>28</sup>

State and local social services and public health agencies experienced overwhelming increases in demand for assistance and services. Early on during the Great Depression, the USCB began collecting data on relief appropriations in ninety-six cities in the United States. In 1929, over eight hundred public and private agencies in these cities spent over \$3.5 million (\$192 million in 2008 dollars) on relief to families.<sup>29</sup> Three years later, in 1932, those same agencies spent close to \$28 million (\$2.7 billion in 2008 dollars) on relief to families, an increase of over 670%.<sup>30</sup> While states and municipalities expanded direct relief spending during the early 1930s, their revenue sources were shrinking, burdening state and local governments with large amounts of debt.<sup>31</sup> In response, state-level appropriations for public health care work dropped an average of seventeen percent by 1933, with some states experiencing reductions as high

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<sup>27</sup> Conrad, James Henry, “Health Services of the United States Children's Bureau, 1935-1953,” PhD Dissertation, The Ohio State University, 1974.

<sup>28</sup> US Senate Committee on Education and Labor, *Rehabilitation and Vocational Education of Crippled Persons*, 15.

<sup>29</sup> Officer and Williamson, “Six Ways to Compute the Relative Value of a U.S. Dollar;” United States Children's Bureau. *Twentieth Annual Report*, 3.

<sup>30</sup> *Ibid.*

<sup>31</sup> Patterson, *The New Deal and the States*, 26.

as seventy-seven percent.<sup>32</sup> Accurate national data about funding for state-level crippled children's programs was not available during this time, but some states did experience a reduction in funding for these programs in their states. Ohio reported spending over \$360,000 (\$20 million in 2008 dollars) on crippled children's services in 1928, but only \$295,000 (\$26 million in 2008 dollars) on the same services in 1934.<sup>33</sup> The State of Michigan spent almost \$54,000 (\$3.4 million in 2008 dollars) on care for its crippled children in 1930, but expenditures dropped to \$51,000 (\$4.5 million in 2008 dollars) in 1934.<sup>34</sup> Private agencies working with crippled children experienced similar declines in spending. The AACC allocated \$45,233 (\$2.6 million in 2008 dollars) in 1928 for services, but six years later in 1934, spent only \$41,628 (\$3.7 million in 2008 dollars) on similar services for its clientele.<sup>35</sup> In 1934, the USCB estimated that overall state-level crippled children's programs were underfunded by almost forty percent.<sup>36</sup>

The political environment of the 1930s presented social reformers with difficulties and opportunities. The Great Depression negatively affected the health and well-being of thousands of children in the United States. On one hand, health care services were cut or terminated because of serious financial problems experienced by the states, the voluntary

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<sup>32</sup> Ravenel, Mazyck, ed. "The Depression and Health Appropriations." *American Journal of Public Health* 23, no. 12 (1933): 1290-1293.

<sup>33</sup> Committee on Economic Security. *Social Security in America: The Factual Background of the Social Security Act*. Washington DC: US Government Printing Office, 1937, 285; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" Smith, Mabel. *The Crippled Child: The Ohio Plan for Care, Treatment and Education*. Columbus, OH: State of Ohio, Department of Public Welfare, Division of Charities Crippled Children's Bureau, 1931, 50.

<sup>34</sup> Committee on Economic Security, *Social Security in America*, 285; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" Upson, Lent Dayton, Opal V. Matson, and Harold Hunter Emmons. *Crippled Children in Michigan: A Study of Their Care, Maintenance and Education*. Detroit, MI: Courier-Berghoff, Inc, 1931, 100-101.

<sup>35</sup> Association for the Aid of Crippled Children, "Twenty-eighth Annual Report", 1928, 22-23, Reel32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC; Association for the Aid of Crippled Children, *Thirty-fourth Annual Report*, 1934, 21, Reel 32, *Annual Reports*, 1909-1996, Foundation for Child Development, Microfilm Collection, RAC; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>36</sup> Committee on Economic Security, *Social Security in America*, 284.

sector, and the federal government. On the other hand, as American children experienced high rates poverty and malnutrition, public and private agencies, social reformers and health care professionals were more willing to try new programs and services arrangements to meet needs. As states governments experienced declines in tax revenues, they became more open to and dependent on federal aid. The working relationships shifted between states and federal government, and the USCB and other advocacy groups were ready to promote the needs of crippled children through a national program.

#### Crippled Children's Services in the Social Security Act

Most experts credit the inclusion of the federal CCS program in the SSA to Grace Abbott. Although Abbott resigned as director of the Children's Bureau in 1934, she remained active in children's affairs in her new position as a professor at the University of Chicago's School of Social Service Administration. Central to her efforts was planning for a new social security program. President Roosevelt established the Committee on Economic Security (CES) in June 1934 to investigate and make recommendations on how to improve economic security for all Americans. Abbott helped her successor as USCB Chief, Katherine Lenroot, and Assistant USCB Chief Dr. Martha Eliot draft recommendations for child health and welfare provisions for what would become the Title V of the SSA. Although President Roosevelt had not envisioned that maternal and child health (MCH) programs would be part of the social security program, Edwin Witte, who became executive director of the Committee in August 1934,

asked Lenroot what provisions for children should be included in the Committee's recommendations.<sup>37</sup>

In their report to the CES, *Security for Children*, Abbott, Lenroot and Elliot included three programs for children: 1) Aid to Dependent Children (ADC); 2) child welfare services for dependent, neglected and delinquent children; and 3) MCH services including the provision of services to crippled children. In an oral history recorded in the early 1970s, Eliot recalled how Abbott brought up the question of crippled children for inclusion in their report:

Then, Grace Abbott said, 'But what about crippled children?' There had [*sic*] been a study by the Bureau, recently, of what the states were doing for crippled children... 'What about having a federal program to support that and extend it to all other states? And what would we include in a crippled children's program?' So, we turned, with pencil in hand, and wrote down the language that we thought might be inclusive to take in such conditions as tuberculosis of the bones of children.<sup>38</sup>

To support their recommendation for a federal crippled children's program, the USCB leaders reported that many crippled children lived in rural areas where orthopedic services were not available. They also argued that without comprehensive after care

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<sup>37</sup> Witte, Edwin. *The Development of the Social Security Act*. Madison, WI: The University of Wisconsin Press, 1963, 32; Schmidt, William M, "How Children Got into the Act," In *Children and Youth in America: A Documentary History*, edited by Robert H. Bremner, John. Barnard, Tamara K. Hareven, and Robert M. Mennel, Volume III, 1933-1973, Parts 5-7: 1211-1213, Cambridge, MA: Harvard University Press, 1974, 1213.

<sup>38</sup> Cheek, Jeannette. *Martha May Eliot Interview. Family Planning Oral History Project*. Cambridge, MA: Schlesinger Library, Radcliffe Institute, Harvard University, 1974, 74.

services like physical therapy, medical equipment, and social services, the effects of medical and surgical treatment were often short-term.<sup>39</sup>

Lela Costin, Abbott's biographer, suggested two reasons why Abbott recommended services for crippled children for inclusion in the SSA.<sup>40</sup> First, Abbott envisioned medical services for crippled children as a precursor to a national health program for all children and possibly all Americans. For years, the American Medical Association (AMA) had been strongly opposed national health care. The AMA's opposition to the STA in the 1920s, which led to its demise, was based on fear that the Act might lead to a national health care system.<sup>41</sup> Abbott believed that few physicians, let alone the AMA, would publicly oppose medical care for crippled children.<sup>42</sup> Second, Abbott believed the program would receive strong support from President Roosevelt, given his own disability. However, President Roosevelt never expressed any particular interest in the CCS program.<sup>43</sup>

Abbott initially envisioned crippled children as a special population served by the broader MCH program, but pressure from private groups working with crippled children, such as the ISCC, resulted in a separate program.<sup>44</sup> The Bureau had a long-standing relationship with the ISCC since the Society was formed in 1919, and often referred inquiries about crippled children from state programs or individuals to the ISCC.

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<sup>39</sup>Lenroot, Katherine, Martha Mae Eliot and the Advisory Committee on Child Welfare, "Security for Children: Report to the Committee on Economic Security, On Child Welfare in a General Program of Social Security, and Special Measures needed for the Protection, Health and Welfare of Children," 23-30, File Special Reports, Box 23, Record Group 47, Records of the Committee of Economic Security, NARA.

<sup>40</sup>Lela Costin, *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott*. Urbana, IL: University of Illinois Press, 1983.

<sup>41</sup>Lemons, *The Sheppard-Towner Act*, 785.

<sup>42</sup>Cheek, *Martha May Eliot Interview*, 147.

<sup>43</sup>Witte, *The Development of the Social Security Act*, 75

<sup>44</sup>Lindenmeyer, *A Right to Childhood*, 189.

Additionally, the Bureau consulted with orthopedic surgeons, regarding their recommendations for orthopedic and medical services for crippled children.<sup>45</sup>

Bureau leaders did specify that the federal CCS program would not just pay medical bills and fund existing state-level services. They noted that state funding for crippled children's programs in 1934 was "so small that the number of children cared for is almost negligible."<sup>46</sup> They proposed that states expand on the current work being done to include case finding, social services, and after care services as well as medical and surgical care. Additionally, Abbott, Lenroot, and Eliot included language that required states to identify and develop plans for preventing "conditions which lead to crippling."<sup>47</sup> This language would require states to develop preventive programs for crippled children as well as curative care, a relatively new approach at time for child health programs in the United States. The Bureau's recommendations were very similar to recommendations produced by the 1930 White House Conference on Child Health and Protection on services for crippled children. Services recommended in the Conference's final report included medical and orthopedic services provided by hospitals and outpatient clinics, social services, educational and after care services, and the development of procedures to locate and assess the needs of crippled children for services.<sup>48</sup>

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<sup>45</sup> "Consultation with Group of Orthopedic Surgeons," June 4, 1935, 1-6, Folder 14-0-4, Box 626, RG 102, NARA.

<sup>46</sup> "Security for Children: Summary of the Report to the Committee on Economic Security on Child Welfare in a General Program of Social Security", File Security for Children, Box 2 Martha Mae Eliot, Record Group 102 Speeches and Articles of Chief of the Children's Bureau, 1924-1967, NARA.

<sup>47</sup> Committee on Economic Security, *Social Security in America*, 284.

<sup>48</sup> White House Conference on Child Health and Protection. *The Handicapped Child: Report of the Committee on Physically and Mentally Handicapped*, New York, NY: The Century Company, 1933, 177-179.

When the CES's final report was sent to the President at the beginning of January 1935, it included the following recommendation about crippled children's services:

Special aid should be given toward meeting part of the expenditure for transportation, hospitalization and convalescence care of crippled and handicapped children, in order that those very necessary services may be extended for a large group of children whose handicaps are physical.<sup>49</sup>

Other recommendations included in the CES's report included unemployment compensation, old-age benefits, mother's pensions, maternal and child health services, national public health services, and the creation of a board to administer the new SSA programs. The original economic security bill, introduced in Congress on January 17, 1935, included the CES's recommendation for services for crippled children.

Both the House Ways and Means Committee and the Senate Finance Committee Hearings held hearings about the economic security bill during January and February of 1935, but the bill languished in Congress for a few months due to controversies and debates over amendments to the bill. Some of the major controversies included opposition from the AMA for a national health care program, the constitutionality of the proposed bill, how the new social security programs would be administered, and the amount of old-age assistance to be provided to individuals.<sup>50</sup> There was little public or private opposition to the inclusion of crippled children services in the SSA.<sup>51</sup> Edwin Witte, executive director of the CES, wrote that congressional testimony about the CCS

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<sup>49</sup> Social Security History, "Report to the President of the Committee on Economic Security," *Committee on Economic Security (CES)*, <http://www.ssa.gov/history/reports/ces/ces.html>.

<sup>50</sup> Witte, *The Development of the Social Security Act*, 98-106.

<sup>51</sup> Altmeyer, Arthur Joseph. *The Formative Years of Social Security*, The University of Wisconsin Press, 1966, 85; Witte, *The Development of the Social Security Act*, 75.

program focused solely on comments about the important work being done by private charitable groups, and that more needed to be done to support state work in this area.<sup>52</sup>

The Bureau anticipated opposition from the AMA and the USPHS, but such opposition did not materialize. Some suggested that the debate on national health insurance in the SSA drew the attention of the AMA away from the Title V child health programs.<sup>53</sup> The lack of objection from the USPHS surprised the Bureau staff. During the 1930 White House Conference on Child Health and Protection, the USPHS aggressively campaigned to take over the Bureau's popular MCH programs, claiming that all federal health programs should fall under the authority of the Surgeon General. The Bureau and its supporters vehemently protested and the proposal was ultimately withdrawn.<sup>54</sup> Four years later, the USPHS was no longer interested in the Bureau's child health programs, as the agency's own programs had expanded under the New Deal legislation and would see further growth under Title VI – the public health programs of the SSA.<sup>55</sup>

The House passed the Social Security bill on April 19, 1935, by a vote of 372 to thirty-three, and the Senate passed the bill on June 19, 1935, by a vote of seventy-seven to six.<sup>56</sup> President Roosevelt signed the SSA into law on August 14, 1935. Final provisions under the Act included programs for old-age assistance, unemployment compensation, ADC, maternal and child welfare, public health, and aid to the blind.

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<sup>52</sup> *Ibid.*

<sup>53</sup> Lindenmeyer, *A Right to Childhood*, 190.

<sup>54</sup> Costin, Lela B. "Women and Physicians: The 1930 White House Conference on Children." *Social Work* 28, no. 2 (1983): 108-14.

<sup>55</sup> The Reminiscence of Martha Eliot (1969), 49-52, in the Oral History Collection of Columbia University; Corning, Peter, *Transcript of Oral History, Katherine Lenroot*. New York, NY: Oral History Research Office, Columbia University, 1965, 100.

<sup>56</sup> Social Security History, "Vote Tallies: 1935 Social Security Act," Social Security Administration, <http://www.ssa.gov/history/tally.html>.

Additionally, the Act authorized a federal program of old-age benefits and the creation of the Social Security Board to administer some of the newly created programs under the SSA. An initial appropriation of \$2.8 million (\$200 million in 2008 dollars) was authorized for a federal CCS program.<sup>57</sup>

The USCB became responsible for administering three of the new SSA programs: MCH services, services for crippled children, and child welfare services. Although the Bureau had originally suggested the creation of ADC, the program was given to the Social Security Board, based on recommendations from the CES. During the drafting of the CES's report to the president, committee members favored administratively grouping ADC with old-age benefits because both programs provided direct financial benefits to recipients.<sup>58</sup> This was a difficult loss for the Bureau and its supporters who had been fighting for a national mother's pensions program for years. Abbott, Lenroot and Eliot had drafted the program's recommendations based on years of research and advocacy by the USCB.<sup>59</sup> Further, it violated the Bureau's philosophy of the "whole child," a perspective that advocated for one federal agency to serve and meet all the needs of all children.<sup>60</sup>

There was also some discussion about the administrative placement of the federal CCS program during the SSA's hearings. Earlier recommendations from the ISCC and the 1930 White House Conference on Child Health and Protection supported a CCS

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<sup>57</sup> National Center for Education in Maternal and Child Health. *Legislative Base: Maternal and Child Health Services Block Grant, Title V of the Social Security Act*. Vienna, VA: National Maternal and Child Health Clearinghouse, 1996, 515-516; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>58</sup> Cauthen, Nancy K. "From Quiet Concern to Controversy: The Transformation of Aid to Dependent Children, 1935-1967." PhD, New York University, 1998, 97-81; Hanlan, Archie. "From Social Reform to Social Security: The Separation of ADC and Child Welfare." *Child Welfare* 45, no. 9 (1966): 493-500.

<sup>59</sup> Hanlan, "From Social Reform to Social Security," 499-500.

<sup>60</sup> Lindenmeyer, *The Right to Childhood*, 2.

program within the Federal Bureau of Vocational Rehabilitation, a division within the FOE, the federal agency responsible for primary and secondary education in the United States. According to Edwin Witte, the CES's executive director, members of Congress did not support placing the CCS program with the FOE during the Congressional hearings, preferring to keep the program with the USCB and its leaders who originally proposed the program.<sup>61</sup> The FOE did become administratively responsible for the vocational rehabilitation services program, Part 4 of Title V of the SSA.

All states and most territories including the District of Columbia were eligible to apply for federal SSA funding, including the CCS program. Puerto Rico became eligible for funding in 1940, bring the total number of state-level CCS programs to fifty-three in 1941.<sup>62</sup> To qualify for funding, states and territories had to develop a plan outlining services provisions, funding capabilities, and cooperation with other state and private agencies working with crippled children.<sup>63</sup> Each state plan had to include "services for locating crippled children and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after care, for children who are crippled or who are suffering from conditions which lead to crippling."<sup>64</sup> See the Appendix C for the text of the original CCS legislation – Part 2 of Title V of the SSA of 1935.

### Conclusion

Although local and state-based services for crippled children had been developing since the late nineteenth century, it took changes in the American political and economic

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<sup>61</sup> Witte, *The Development of the Social Security Act*, 190.

<sup>62</sup> United States Department of Labor. *Twenty-eighth Annual Report of the Secretary of Labor*. Washington, DC: Government Printing Office, 1940, 152.

<sup>63</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

<sup>64</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

systems to create conditions that supported the development of federal funding for crippled children's programs. Grant-in-aid programs of the 1920s established a precedent for more collaborative relationships between the federal and state governments. Recognition of the importance of crippled children's program by the USCB provided support from within the federal government, and the economic problems of the 1930s encouraged social reformers across the country to demand federally-funded programs for children. Lending an urgency to campaign for a federal CCS program, data compiled by the USCB during the 1930s suggested that crippling conditions among children were on the rise while state and voluntary agency budgets were being cut. The inclusion of services for crippled children into the SSA provided social reformers and child health advocates an opportunity to expand services to all states and to develop a national preventive and medical program for crippled children.

## CHAPTER 5

### THE EARLY YEARS OF THE CRIPPLED CHILDREN'S SERVICES FROM THE FEDERAL PERSPECTIVE, 1935-1941

*“For the purpose of enabling each State to extend and improve...”*  
Section 511, Part 2 – Services for Crippled Children of Title V- Grants to States for Maternal and Child Welfare of the Social Security Act<sup>1</sup>

The Crippled Children's Service (CCS) program was a new departure for the United States Children's Bureau (USCB). The Bureau operated a maternal and child health (MCH) program under the Sheppard-Towner Act (STA) from 1921 to 1929, which included the development of prenatal and child health centers, educational conferences on pregnancy and child health, home visits by nurses, and the distribution of educational pamphlets.<sup>2</sup> But never before had the Bureau been involved in the provision of medical services. In 1935, the Social Security Act (SSA) authorized the USCB to implement and manage the CCS program along with other Title V services.<sup>3</sup> Bureau Chief Katherine Lenroot had knowledge and experience in administering maternal and child health (MCH) programs, as she had been assistant chief when the USCB administered the STA's programs during the 1920s. She recognized that the CCS program opened a new area of effort for the federal government and for the USCB, and would require new and

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<sup>1</sup> National Center for Education in Maternal and Child Health. *Legislative Base: Maternal and Child Health Services Block Grant, Title V of the Social Security Act*. Vienna, VA: National Maternal and Child Health Clearinghouse, 1996, 515.

<sup>2</sup> Meckel, Richard A. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*. Ann Arbor, MI: Ann Arbor Paperbacks, 1998, 212-213.

<sup>3</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

innovative approaches. The Bureau needed new policies and guidelines to administer and monitor preventive and medical services for crippled children.

Additionally, the SSA mandated specific requirements for state-level agencies applying for federal funding under the CCS grants. These requirements included financial contributions from the state and territories, selection of a state-level agency to administer the program, development of a specific state-level plan to guide the operations of the program, and mandatory reporting requirements to the USCB. The Act also required state agencies to cooperate with other child health and welfare programs throughout the state, both public and private programs.<sup>4</sup> The mandate to cooperate with other programs was unique to the MCH and CCS programs of Title V programs within the SSA. The USCB leaders, Grace Abbott, Katherine Lenroot, and Martha May Eliot, included the last requirement of cooperation into the SSA to ensure that state-level agencies would create advisory committees and that a broad spectrum of services would be provided to crippled children.<sup>5</sup>

To be eligible for CCS funding, state and territorial agencies submitted service plans to the USCB for approval.<sup>6</sup> After a plan was approved, the federal government released funding to the state CCS agency, which, in turn, reported to the USCB on services provided to crippled children for each fiscal year of funding. During the first years of the federal CCS program, the USCB focused on developing new policies and

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<sup>4</sup> National Center for Education in Maternal and Child Health. *Legislative Base: Maternal and Child Health Services Block Grant, Title V of the Social Security Act*. Vienna, VA: National Maternal and Child Health Clearinghouse, 1996, 516.

<sup>5</sup> Cheek, Jeannette. *Martha May Eliot Interview. Family Planning Oral History Project*. Cambridge, MA: Schlesinger Library, Radcliffe Institute, Harvard University, 1974, p. 74; "Minutes of the Conference on Crippled Children's Program," October 27, 1936, 6, Folder CB Crippled Children's Division (Source Material), Box 22 Dept. of Labor, RG 220, FDR Library.

<sup>6</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

guidelines for expanding, monitoring, and improving state-level services for crippled children.

#### Administration of the Federal CCS Program

After President Roosevelt signed the SSA into law on August 14, 1935, the Children's Bureau quickly developed plans to expand the Bureau's structure and personnel to administer the three new Title V programs: MCH services, CCS, and Child Welfare Services. The USCB had been located administratively within the United States Department of Labor since the Bureau's establishment in 1912, and Lenroot quickly consulted with the Secretary of Labor Francis Perkins regarding the Bureau's plans for expansion under the SSA. In a memo dated August 15, 1935, just one day after Roosevelt signed the SSA into law, Lenroot proposed to Perkins the creation of three new divisions within the Bureau corresponding to the three Title V programs assigned to the Bureau.<sup>7</sup> The divisions included the Maternal and Child Health (MCH) Division, the Crippled Children's (CC) Division, and the Child Welfare (CW) Division. Each division had its own director, and Lenroot hired Dr. Robert C. Hood, a pediatrician from West Virginia who was very involved in crippled children's services in his state, to head up the CC Division. Additionally, the Bureau hired a team of professional health care workers for the CC Division, including a public health nurse, a medical social worker, and a nutritionist. By hiring professional health care experts, not program administrators, the USCB acknowledged that staff members at the federal-level needed expertise in the various social and medical services for crippled children that would be developed at the

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<sup>7</sup> Lenroot to the Secretary of Labor, "Plans for Administration of the Child Health and Child Welfare Services under the Social Security Act," August 15, 1935, 1, Folder 14-1-0, Box 626, RG102, NARA.

state-level.<sup>8</sup> Lenroot placed the MHC and CCS divisions under the general direction of Assistant Bureau Chief, Dr. Martha May Eliot. She hoped Eliot's status as a physician would encourage cooperation among other federal agencies such as the United States Public Health Service (USPHS) and the federal Vocational Rehabilitation Services program in the Office of Education (FOE), which was responsible for administering vocational rehabilitation services under the SSA.<sup>9</sup>

The Bureau also established five regional administrative units that provided consultation to states and territories for all three Title V programs throughout the nation.<sup>10</sup> Designed to be interdisciplinary, each unit included a physician, a public health nurse, a medical social worker, and an auditor. Regional staff members assisted state agencies in developing services plans for all of three Title V programs, and conducted field visits to monitor the Title V work at the state and local levels. The Bureau operated three offices for its regional staff in San Francisco, New Orleans and Washington, DC.<sup>11</sup> To facilitate communication between the central and regional offices, the USCB held bi-annual conferences for all regional and central office staff members. Central office staff members such as Dr. Eliot and Dr. Hood also went out into the field to conduct state-level site visits with regional staff members.<sup>12</sup> Regional staff members of the USCB also worked cooperatively with other Bureau programs, other federal agencies such as the

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<sup>8</sup> Cheek, *Martha May Eliot Interview*, 81.

<sup>9</sup> Corning, Peter, *Transcript of Oral History, Katherine Lenroot*. New York, NY: Oral History Research Office, Columbia University, 1965, 47.

<sup>10</sup> Lenroot to the Secretary of Labor, "Plans for Administration of the Child Health and Child Welfare Services under the Social Security Act," August 15, 1935, 2, Folder 14-1-0, Box 626, RG102, NARA; 1937 annual report, p114.

<sup>11</sup> United States Department of Labor. *Twenty-Fourth Annual Report of the Secretary of Labor*. Washington, DC: Government Printing Office, 1936, 123.

<sup>12</sup> Cheek, *Martha May Eliot Interview*, 89.

FOE's Vocational Rehabilitation Services, and regional staff from other federal agencies such as the Bureau of Indian Affairs and the USPHS.<sup>13</sup>

State agencies welcomed input from the regional USCB staff because some states were unfamiliar with how to administer services to crippled children. Seventeen states and territories, including the District of Columbia, had no state-level programs for crippled children prior to 1935.<sup>14</sup> One request from Wyoming State Department of Public Health, a state without a crippled children's program prior to 1935, stated "even though you have been very kind and patient in showing us about the plans for the Social Security program there seem to remain a few points which need clearing up."<sup>15</sup> Even states with more experience in providing services for crippled children requested help from regional staff. The Director of the Crippled Children's Division in Wisconsin, a state with services for crippled children going back to the late 1880s, stated in a letter to a regional staff member on November 30, 1935, "I had hoped that you would be able to visit Wisconsin some time soon to give us advice as to our proposed plans for extending the service."<sup>16</sup> By December 1935, 16 states had requested visits from regional staff members regarding their Crippled Children's state plans.<sup>17</sup>

Lenroot also recommended the establishment of four advisory committees to help guide the Bureau in the development of the new Title V programs.<sup>18</sup> The four committees were: 1) the General Advisory Committee on Maternal and Child Welfare

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<sup>13</sup> Hays to Van Horn, April 26, 1939, 1, Folder 14-2-1(3), Box 943, RG 102, NARA; Dunham to Eliot, "Visit to Oklahoma," September 30, 1936, 1, Folder 13-2-3 (38), Box 623, RG 102, NARA.

<sup>14</sup> Committee on Economic Security. *Social Security in America*. Washington, DC: US Government Printing Office, 286.

<sup>15</sup> *Ibid.*

<sup>16</sup> *Ibid.*

<sup>17</sup> "Requests for Field Consultants to Visit States Crippled Children's Program," January 31, 1936, Folder 14-2-0, Box 626, RG 102, NARA.

<sup>18</sup> Lenroot to the Secretary of Labor, "Plans for Administration of the Child Health and Child Welfare Services under the Social Security Act," August 15, 1935, 2, Folder 14-1-0, Box 626, RG102, NARA.

Services; 2) the Advisory Committee for Maternal and Child Health; 3) the Advisory Committee on Services for Crippled Children; and 4) the Advisory Committee on Community Child Welfare Services. Other advisory committees were appointed in later years as the Title V programs developed and matured under the USCB. For example, in July 1937, the Bureau created the Advisory Committee on Dental Health to guide the MCH program on issues of oral health among children, and, in May 1938, the Bureau, in conjunction with the Social Security Board, established the Advisory Committee on Training and Personnel for Child Welfare Services.<sup>19</sup>

The USCB had a strong precedent of using advisory committees to guide its work. A 1939 memorandum to Lenroot noted interest in the Bureau's advisory committees by the National Resources Committee, a federal agency charged with advising President Roosevelt on the planned development of national resources, because the USCB made "more use of advisory committees than any other Federal agency."<sup>20</sup> The USCB created its first advisory committee, the Pediatric Advisory Committee, to advise Bureau staff on issue related to infant mortality in 1919.<sup>21</sup> Composed of four physicians, the committee provided expert advice on infant and childcare for the Bureau's popular publication *Infant Care*.<sup>22</sup> A second committee, established in 1926, offered guidance on maternal and obstetric care.<sup>23</sup> Both of these committees focused on technical matters related to maternal and child health care, not on policy development. Another committee, the Advisory Committee on Current Statistics, was created in 1930 when the USCB began

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<sup>19</sup> Rockwood to Lenroot, "Memorandum," May 12, 1939, 10-12, Part 3, Reel 9, The Records of the Children's Bureau 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

<sup>20</sup> *Ibid*, 1.

<sup>21</sup> *Ibid*, 2.

<sup>22</sup> United States Children's Bureau. *Infant Care*. Washington, DC: Government Printing Office, 1914.

<sup>23</sup> Rockwood to Lenroot, "Memorandum," May 12, 1939, 3, Part 3, Reel 9, The Records of the Children's Bureau 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

collecting statistics about relief efforts in many American cities, and provided the Bureau with technical assistance on statistical research.<sup>24</sup>

The USCB wanted guidance from the new advisory committees about establishing administrative policies as well as technical expertise for each of the new programs. Lenroot especially wanted insight on how to best foster cooperation among the different child health and welfare programs, both locally and nationally.<sup>25</sup> The SSA explicitly required states seeking Title V funding to cooperate within all child health and welfare programs within their states. For the CCS program, state agencies were required to cooperate “with medical, health, nursing, and welfare groups and organizations and with any agency in such State charged with administering State laws providing for vocational rehabilitation of physically handicapped children.”<sup>26</sup> Members of these new advisory committees included child health and welfare experts such as Paul King of the International Society of Crippled Children (ISCC), Dr. Thomas Parran of the New York State Health Department, and Edith Baker of the American Association of Medical Social Workers (AAMSW).<sup>27</sup> The Advisory Committee for Crippled Children included eleven members, of whom seven were physicians, one was a medical social worker, one a public health nurse, and two were representatives of state-level crippled children programs. By 1939, this Committee’s membership had expanded to nineteen professionals, including

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<sup>24</sup> Rockwood to Lenroot, “Memorandum,” May 12, 1939, 4, Part 3, Reel 9, The Records of the Children’s Bureau 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

<sup>25</sup> “Report of the Meeting of the Advisory Committees on Maternal and Child Welfare Services Under the Social Security Act,” December 16 and 17, 1935, 1, MCH Library.

<sup>26</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

<sup>27</sup> “Report of the Meeting of the Advisory Committees,” December 16 and 17, 1935, 44-45, MCH Library.

experts from the previously unrepresented fields of education, physical therapy, and vocational rehabilitation.<sup>28</sup>

Anxious to get to work, Lenroot pushed the advisory committees to meet in September 1935, but the first meetings of the committees were not held until December.<sup>29</sup> At its first meeting, the Advisory Committee on Services for Crippled Children dealt primarily with issues related to the design and implementation of the state-level CCS programs. Because most of the committee's members were health care professionals, the committee quickly established its role as one of providing advice and assistance on program development, service provision, and professional development. At its first meeting, the Committee referred the one financial matter Bureau leaders presented, an issue on the required financial participation by state governments in the CCS programs, back to the Bureau, recommending consultation with the Secretary of the Department of Labor.<sup>30</sup> As a result, the USCB referred all future legal and financial questions about Title V programs to the Department of Labor's Office of the Solicitor.<sup>31</sup>

Other recommendations from the Advisory Committee on Services for Crippled Children included: 1) the Bureau work with already established state-level CCS programs to promote a variety of state plans for crippled children's services; 2) that only Board Certified Physicians or Surgeons should be eligible to serve as directors of state CCS programs and other personnel should be equally qualified in their fields; 3) the Bureau develop reporting procedures for state agencies to account for their services and

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<sup>28</sup> Lenroot to the Secretary of Labor, "Meeting of Advisory Committee on Services for Crippled Children," October 27, 1939, 5-6, Folder 14-2-0-2, Box 936, RG 102, NARA.

<sup>29</sup> Lenroot to the Secretary of Labor, "Plans for Administration of the Child Health and Child Welfare Services under the Social Security Act," August 15, 1935, 1, Folder 14-1-0, Box 626, RG102, NARA.

<sup>30</sup> Report of the Meeting of the Advisory Committees," December 16 and 17, 1935, 18-20, MCH Library.

<sup>31</sup> United States Department of Labor. *Twenty-fourth Annual Report of the Secretary of Labor*, 123.

programs; 4) that no one definition of crippling condition be established for the program, but that states should establish their own definitions; and 5) that state CCS agencies cooperate with other medical, welfare and social service programs throughout their states in an effort to address the needs of "the whole child."<sup>32</sup> The CCS Advisory Committee met annually and provided valuable suggestions and advice to the USCB during the program's early years.

Administration of CCS programs at the state-level varied across the country. The original text of the SSA outlining services for crippled children (less than one thousand words) gave state and territorial governments significant flexibility in designing and implementing their programs. The main requirements under the SSA included that: 1) only one state agency administer the program; 2) plans must be approved by the USCB; and 3) funding would be revoked if a state failed to follow its plan. As a result, states and territories without CCS programs prior to 1935 developed entirely new programs for their states, and states with established crippled children's programs prior to 1935 worked to expand their services.<sup>33</sup> As noted in Chapter 2, prior to the SSA, the type of state agency responsible for administering the CCS program varied from state to state. In some states, health departments administered the plan while in others education departments or crippled children's commissions were responsible. Many states and territories located their crippled children's programs within departments of public health. By 1938, almost one-half of all state CCS programs were administered by a state health department.

Table 8 presents the breakdown of state-level agencies responsible for CCS

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<sup>32</sup> "Report of the Meeting of the Advisory Committees," December 16 and 17, 1935, 18-20, MCH Library.

<sup>33</sup> Eliot, Martha M. "The Social Security Act and Crippled Children." *The Crippled Child* 14, no. 3 (1936): 35-37.

Table 8. Types of State and Territorial Agencies including the District of Columbia Administering CCS Programs in 1934 and 1938

Type of State and Territorial Agency	Number of Agencies in 1934	Number of Agencies in 1938
Education	2	3
Public Health	6	25
Crippled Children's Commission	3	5
State Hospital	5	1
Public Welfare	5	11
Other (Boards of Control, Dept. of Institutions)	5	6
Unknown	2	0
<b>Total</b>	<b>37</b>	<b>51*</b>

*Sources:* Committee on Economic Security. *Social Security in America*, 285; United States Children's Bureau. *Services for Crippled Children Under the Social Security Act, Title V, Part 2*, 25.

\*Includes Alaska, Hawaii and the District of Columbia. Puerto Rico would become eligible for services in 1940.

programs before and after the passage of the SSA. The USCB implemented a recommendation of the Advisory Committee on Services for Crippled Children and mandated states to hire Board Certified Physicians or Surgeons as state directors of CCS program. Additionally, the Bureau directed states to establish their own state advisory committees.<sup>34</sup>

The Children's Bureau also organized regional and national meetings for state and territorial directors of CCS programs. Regional meetings were often held in conjunction with other regional conferences that the Bureau organized in cooperation with the Social Security Board and the United States Public Health Services (USPHS). For example, the Bureau coordinated a joint regional conference with the USPHS in San Francisco on January 26-28, 1937 for state and territorial public health officers from the Western part of the United States.<sup>35</sup> The state-level CCS directors from the same area met the following day, January 29, 1937.<sup>36</sup> Topics discussed at the January 29<sup>th</sup> meeting included how to complete budget reports, the qualification standards for professional staff, and the role of the USCB in administering the CCS program. Regional meetings provided state-level CCS directors an opportunity discuss issues relevant to their region of the country with each other, regional staff members, and Bureau staff members from the central office. Examples of issues discussed at regional meeting included state-county relationships, the development of budgets, and how to locate crippled children for services.<sup>37</sup>

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<sup>34</sup> "Minutes of the Conference on Crippled Children's Program," October 27, 1936, 6, Folder CB Crippled Children's Division (Source Material), Box 22 Dept. of Labor, RG 220, FDR Library.

<sup>35</sup> United States Children's Bureau. *Twenty-fifth Annual Report of the Chief of the Children's Bureau*. Washington, DC: Government Printing Office, 1937, 115.

<sup>36</sup> *Ibid.*

<sup>37</sup> "Minutes of the Conference on Crippled Children's Program," October 27, 1936, 6, Folder CB Crippled Children's Division (Source Material), Box 22 Dept. of Labor, RG 220, FDR Library.

National meetings for state-level CCS directors were often scheduled in conjunction with the annual conferences of the Association of State and Territorial Health Officers (ASTHO), a professional organization for directors and health officers of state-level departments of public health, as many state and territorial CCS directors were part of the organization. These meetings also afforded state-level CCS agencies a forum to give feedback and recommendations to the USCB. State directors also met individually with USCB staff during these conferences to address needs specific to their states. These national meetings served to develop and maintain cooperative relationships between the USCB and the state-level CCS agencies, by providing an opportunity for state agencies to meet and exchange ideas, and by educating state personnel about technical and clinical issues related to the CCS program.<sup>38</sup>

#### *Unique Features of the Federal CCS Program*

Unlike the MCH program, the CCS program offered funding to states and territories for new and innovative services for crippled children never before supported by the federal government, beyond simply providing for a new class of beneficiaries. An example how the CCS program brought the federal government into new areas of effort was the inclusion of prevention in the design and execution of state-based services. A report from the 1930 White House Conference on Child Health and Protection noted there were few national efforts focused on the prevention of crippling conditions among children, but that “more effort is being expended on the salvage of crippled children than

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<sup>38</sup> “Report of the Regional Conference of Directors of Crippled Children with Representatives of US Children’s Bureau, San Francisco, California, January 29, 1937,” Folder 14-0-4-2, Box 936, RG 102, NARA.

upon the prevention of the causes which disable them.”<sup>39</sup> Efforts to protect children from exposure to disease or injury that led to crippling conditions (also known as primary prevention) had typically fallen to public health officials rather than orthopedic specialists. Examples of these efforts included the development of milk stations, improved dietary and housing conditions, better access to prenatal care, and safety campaigns, especially for working children.<sup>40</sup> Most health care professionals and experts working with crippled children focused on secondary forms of prevention, “the form of early care...which seeks to prevent deformity after the incidence of disease, accident, or other condition likely to leave a child crippled.”<sup>41</sup>

The federal CCS program endeavored to include both primary and secondary levels of prevention in state-level CCS programs. The original language of the SSA stated that programs needed to serve “children who are crippled or who are suffering from conditions which lead to crippling.”<sup>42</sup> By including “conditions which lead to crippling,” the SSA encouraged state agencies to include services for conditions beyond the traditional orthopedic disorders such as rheumatic heart fever and cerebral palsy. USCB leaders Katherine Lenroot, Grace Abbott, and Dr. Martha Eliot drafted this language for the Act because they wanted states to develop programs that met the needs of children in their own states.<sup>43</sup> In later years, Lenroot wrote that she and Dr. Eliot initially encouraged state-level CCS directors to focus their programs on orthopedic

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<sup>39</sup> White House Conference on Child Health and Protection. *The Handicapped Child: Report of the Committee on Physically and Mentally Handicapped*, New York, NY: The Century Company, 1933, 175.

<sup>40</sup> Solenberger, Edith Reeves. “Crippled Children.” In *Social Work Year Book 1929*, edited by Fred Hall, 114-118. New York, NY: Russell Sage Foundation, 1930, 115.

<sup>41</sup> Solenberger, Edith Reeves. “Crippled Children.” In *Social Work Year Book 1933*, edited by Fred Hall, 113-116. New York, NY: Russell Sage Foundation, 1933, 114.

<sup>42</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, pp. 515-516.

<sup>43</sup> Cheek, *Martha May Eliot Interview*, 87-91.

ailments among children, in part, due to high rates of polio throughout the country.<sup>44</sup> But evidence suggests that state governments and professional experts quickly included treatment for non-orthopedic conditions into their programs. For example, at its first meeting in 1935, the Advisory Committee on Services for Crippled Children recommended that special programs be established for children with cerebral palsy.<sup>45</sup> By 1940, several state and territorial CCS programs treated children for such conditions as rheumatic heart fever, severe dental malformations, hernias and diabetes.<sup>46</sup> Additionally, the USCB regularly collected data from the state CCS programs on the number of children with such conditions as cleft plates, harelips and congenital syphilis.<sup>47</sup>

Despite their original intent, the USCB leadership later encouraged the expansion and development of services for children suffering from all types of physical handicaps. They did not define what qualified as a crippling condition in their policies and procedures. The SSA did not provide a definition a crippling condition, and the Bureau did not attempt to offer one either. Instead, the Bureau allowed states to set their own definitions of what constituted a crippling condition. In response to a letter of inquiry on the subject in 1937, Lenroot wrote, “we have felt that we ought not adopt rigid requirements that would mean the limitation of the program to orthopedic cases merely.”<sup>48</sup> By 1939, sixteen states and territories (31%) had created a legal definition of

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<sup>44</sup> The Reminiscences of Katherine Lenroot (1969), 99, in the Oral History Collection of Columbia University.

<sup>45</sup> “Report of the Meeting of the Advisory Committees,” December 16 and 17, 1935, 20, MCH Library.

<sup>46</sup> Van Horn to Hood, “Legal Definition of a Crippled Child as Given in State Statues with Special Reference to Development of the Program of Services for Children suffering from Rheumatic Heart Disease,” August 31, 1939, 4-5, Folder14-0-1-1, Box 936, RG 102, NARA.

<sup>47</sup> Yerushamly to Van Horn, “Material from the Last Special Diagnostic Report of Crippled Children on State Registers,” November 22, 1941, Folder 14-2-7 (0), Box 290, RG 102, NARA.

<sup>48</sup> Lenroot to MacEwen, January 23, 1937, 1, Folder 14-0-1-1, Box 936, RG 102, NARA.

a crippled child in their state laws and policies.<sup>49</sup> This proved problematic when the USCB made funds available in 1940 for states to develop services specifically for children with rheumatic heart disease and other heart-related conditions. States and territories with specific definitions for a crippled child had to change their statutes in order to be eligible for the federal CCS funding. By promoting a vague definition of what qualified children for services, the USCB helped state-level CCS programs to focus services on the unique needs of children in their states, and to develop new services over time, especially for children with non-orthopedic conditions such as cerebral palsy and rheumatic heart disease.

Secondary preventive services required under the federal CCS program included services for locating crippled children and screening and diagnostic services. The USCB wanted states to provide services for locating crippled children so that children in rural and economically distressed communities, areas traditionally under-served by both public state-level programs and private urban-based agencies in the past, could receive services. Also, locating these children was important because of the need for accurate national data about crippled children. Initially, state-level agencies struggled to locate all crippled children within state borders. Not only was the CCS program new for many states and territories, states with established programs needed to modify their record and data collection procedures and create a permanent state registry of crippled children.<sup>50</sup> Early methods used by state agencies to find crippled children included mobile diagnostic and

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<sup>49</sup> Van Horn to Hood, "Legal Definition of a Crippled Child as Given in State Statutes with Special Reference to Development of the Program of Services for Children suffering from Rheumatic Heart Disease," August 31, 1939, 1, Folder14-0-1-1, Box 936, RG 102, NARA.

<sup>50</sup> Williamson, Marian. "Finding the Crippled Child." In the *Proceedings of the National Conference of State Directors of Crippled Children's Services*, pp. 31-33. Washington DC, 1938, Part 4, Reel 40, The Records of the Children's Bureau 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

screening clinics, home visits, referrals from other state and private agencies serving children and families, reviewing reports from hospitals and birth certificates, and publicity.<sup>51</sup>

After a crippled child was located and diagnosed by a state-level CCS program, the child's information was included on its state registry. By 1939, all state-level CCS programs had developed state registries for crippled children. Table 9 shows the number of registered crippled children reported to the USCB from 1936 to 1940 as well as the increase in states and territories locating and registering children. State programs did not adequately register all children within their states during these early years of federal funding. An analysis by the USCB in 1941 found that children under the age of five years and children of color were underrepresented on the state registries. For example, in 1938, children under the age of five years comprised twenty-seven percent of all children in the United States, but only nineteen percent of all crippled children on state registries.<sup>52</sup> Further, children of color represented twelve percent of all children, but only nine percent of all crippled children on state registries.<sup>53</sup> Despite these limitations, the USCB started compiling and publishing data from the state registries in the 1940s, which became one of the first national data sources on the status of crippled children in the United States. Published examples of these compiled statistics included a series titled

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<sup>51</sup> "Conference on Crippled Children's Service," April 6, 1938, 14-16, Part 4, Reel 40, The Records of the Children's Bureau 1912-1969, Microfilm Collection, Alexandria, VA: Chadwyck-Healey, Inc.

<sup>52</sup> United States Children's Bureau. *Services for Crippled Children under the Social Security Act, Title V, Part 2: Development of Program, 1936-1939*. Publication No. 258. Washington DC: US Government Printing Office, 1941, 3.

<sup>53</sup> *Ibid*, 34

*Facts about Crippled Children*, published from 1941 to 1944, and articles published in the Bureau's monthly publication, *The Child* (1936-1953).<sup>54</sup>

While some states had provided after care services for crippled children prior to 1935, the federal CCS program required that all states and territories include these services in their state plans, offering another level of prevention for crippled children.<sup>55</sup> After care services were typically provided following a medical or surgical procedure, and included nursing services, convalescent care, social services, and physical and occupational therapies to ensure a child properly recovered and achieved the full benefits of the medical intervention.<sup>56</sup> These services represented tertiary preventive services that were intended to stop a disability from becoming a dependency.<sup>57</sup> By requiring after care services in all state-level plans, the federal government ensured that crippled children discharged from hospitals received needed care so that the benefits of surgery or other medical treatment were not lost or diminished due to lack of follow-up care. Providing after care services was especially important for children from rural communities where follow-up services were often not available.<sup>58</sup> Types of services provided by state agencies included medical and nursing supervision, physical therapy, educational

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<sup>54</sup> "Crippled Children on State Registers." *The Child* 3, no. 9, Supplement 3 (1939): 3-11; Gooch, Marjorie. "Crippling Conditions Found Among Children on State Registers, December 31, 1939." *The Child* 4, no. 12, Supplement 4 (1940): 3-15; United States Children's Bureau. *Facts about Crippled Children, 1941*. Publication No. 239. Washington, DC: Government Printing Office, 1941; United States Children's Bureau. *Facts About Crippled Children, 1942*. Publication No. 240. Washington, DC: Government Printing Office, 1942; United States Children's Bureau. *Facts about crippled children, 1943*. Publication No. 293. Washington, DC: Government Printing Office, 1943; US Children's Bureau. *Facts about Crippled Children, 1944*. Publication No. 293. Washington, DC: Government Printing Office, 1944.

<sup>55</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

<sup>56</sup> Hood, Robert C. "Crippled Children." In *Social Work Year Book 1937*, edited by Russell H Kurtz, 112-117. New York, NY: Russell Sage Foundation, 1937, 115.

<sup>57</sup> Pickett, George, and John Hanlon. *Public Health: Administration and Practice*. 9th ed. St. Louis, MO: Times Mirror/Mosby College Publishing, 1990, 83.

<sup>58</sup> Committee on Economic Security. *Social Security in America*. Washington, DC: US Government Printing Office, 1937, 286.

Table 9. Data on Expansion of State and Territorial Crippled Children's Registries, 1936-1940

	1936*	1937	1938	1939	1940
Reported Number of Registered Crippled Children	97,000	133,000	172,000	249,000	266,000
Number of Programs Registering Crippled Children	36	44	50	51	52

*Sources:* "Federal funds, paid to States for Services for Crippled Children under the Provisions of Title V, Part 2, of the Social Security Act, Fiscal Years 1936-1904, Inclusive; and Amounts Budgeted, Fiscal year 1941," November 1, 1940, 1, Folder 14-2-5(0), Box 940, RG 102, NARA; United States Children's Bureau, *Services for Crippled Children under the Social Security Act*, 25; United States Department of Labor. 1940. *Twenty-eighth Annual Report of the Chief of the Children's Bureau*, 170.

\*Only five months of funding during this year.

services, transportation, convalescent care, foster home care, and medical social services. Public health nurses, physical therapists, and medical social workers provided these after care services in a variety of settings such as the child's own home, schools, convalescent facilities, and foster care homes.

Another important innovation of the federal CCS program was the emphasis placed on interdisciplinary services and cooperation among health, welfare, and education agencies and groups at the state-level. Long before the creation of the federal CCS program, health care professionals recognized that comprehensive medical and social care for crippled children required services from primary care physicians, orthopedic surgeons, nurses, medical social workers, physical therapists, vocational rehabilitation specialists, and educators. The SSA directed states to provide a wide range of corrective and after care services for crippled children, thus guaranteeing that state programs would hire physicians, surgeons, public health nurses, social workers and other professionals to implement their programs. Perhaps more important was the SSA's requirement that states and territorial programs actively cooperate with other state-level agencies and private programs providing services to children.<sup>59</sup> As a result, state and territorial CCS programs could not operate in isolation, but needed to develop working relationships with other state agencies, hospitals, clinics, and private charities serving crippled children in their states. Examples of these organizations included state affiliates of the ISCC, local medical societies, university hospitals, and county child welfare agencies. Additionally, the USCB developed its own working relationships within the federal government and with private national organizations. Specifically, Bureau leaders

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<sup>59</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516.

met regularly with officials from the USPHS, the Bureau of Indian Affairs, and the FOE's Vocational Rehabilitation Service. Outside of the federal government, the Bureau maintained close ties with the ISCC and the ASTHO.<sup>60</sup>

### Extending and Improving Services for Crippled Children

The SSA outlined two main goals for the federal CCS program: 1) to extend needed medical and social services to crippled children across the country; and, 2) to improve these services, both in established state programs and future programs. To achieve these goals, the USCB initially received \$2.8 million in 1936 (\$200 million in 2008 dollars) to administer grants to states and support its own work.<sup>61</sup> States were eligible to receive a standard \$20,000 grant each year (\$1.4 million in 2008 dollars), that needed to be matched dollar for dollar by the state government.<sup>62</sup> In 1937, the first full year of federal CCS funding, thirty-nine states received these matching grants, which amounted to a total of \$780,000 in federal contributions (\$51 million in 2008 dollars). This was about fourteen percent of the estimated \$5.5 million spent on services for crippled children in 1934. Not all states received a federal \$20,000 grant because they could not match the full amount.<sup>63</sup> Given the potential for fifty-one state-level CCS programs in 1937 (Puerto Rico was not eligible for funding until 1940), these matching grants could have totaled \$1,020,000 in federal contributions (\$67 million in 2008

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<sup>60</sup> Hood, Robert C, "Memorandum on Work of Crippled Children's Division for Use of Interdepartmental Committee on Health and Welfare," 1936, Folder CB Crippled Children's Division (Source Material), Container 22 Dept. of Labor, RG 220, FDR Library.

<sup>61</sup> National Center for Education in Maternal and Child Health. *Legislative Base*, 515-516; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>62</sup> Lenroot, Katharine F. "Maternal and Child Welfare Provisions of the Social Security Act." *Law and Contemporary Problems* 3, no. 2 (1936): 253-262.

<sup>63</sup> United States Children's Bureau. *Services for Crippled Children under the Social Security Act*, 5.

dollars), or about nineteen percent of the initial \$5.5 million spent on services for crippled children in 1934.

The Bureau also distributed the federal funds to states based upon need, and did not require these additional funds to be matched. The Bureau based its determination of state need on four factors: 1) the number of persons under 21 years of age in the state compared to national averages, 2) higher than average number of crippled children in the state, 3) the cost of services for crippled children in the state, and 4) the amount of state funds available for services.<sup>64</sup> In 1937, the USCB distributed a little over \$1.8 million dollars (\$118 million in 2008 dollars) in non-matching funds to states.<sup>65</sup> These grants ranged from as little as \$663.23 for Alaska (\$43,600 in 2008 dollars) to \$138,701.76 for Ohio (\$9 million in 2008 dollars).

#### *Expansion of State and Territorial CCS Programs*

After Congress enacted the SSA in 1935, state and territorial governments quickly applied for funding to develop or expand their own crippled children's services. By 1936, the Children's Bureau had approved thirty-eight state plans, and by 1941, every state, eligible territory, and the District of Columbia had established a CCS program funded by the federal government.<sup>66</sup> Table 10 shows the number of states and territories with approved plans for CCS programs from 1936 to 1940, and the amount of federal payments to states for these years. The largest annual increase occurred between 1936 and 1937. Federal appropriations to state and territorial CCS programs also increased steadily during the first five years of the program, from \$732,000 in 1936 (\$52 million in

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<sup>64</sup> United States Department of Labor. *Twenty-fourth Annual Report of the Secretary of Labor*, 116.

<sup>65</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" United States Children's Bureau. *Twenty-fifth Annual Report of the Chief of the Children's Bureau*, 108.

<sup>66</sup> Eliot, "The Social Security Act and Crippled Children,"36.

2008 dollars) to \$3.3 million in 1940 (\$201 million in 2008 dollars).<sup>67</sup> This represented a twenty-eight percent increase in federal funding for CCS programs from 1936 to 1940.

The initial \$2.8 million (\$200 million in 2008 dollars) appropriated for the federal CCS program was considerably less than the \$5.5 million dollars (\$493 million in 2008 dollars) the USCB projected was spent annually on care for crippled children in 1934 by thirty-five state programs.<sup>68</sup> However, the \$5.5 million was an estimate from the USCB because twelve states did not report the amount appropriated for services to crippled children in 1934. Only twenty-three states reported actual public funding for crippled children's program in 1934, for a total of about \$3.7 million (\$332 million in 2008 dollars).<sup>69</sup> Table 11 shows state and federal funding for services to crippled children before and after the SSA. While state-level public contributions to crippled children's programs were higher prior to the passage of the SSA, overall contributions by states and territories to CCS programs did increase during the late 1930s. In 1937, states and territories provided \$2.5 million (\$164 million in 2008 dollars) in overall funding to their CCS programs, and this funding increased to \$2.8 million (\$186 million in 2008 dollars) in 1939.<sup>70</sup> Additionally, federal contributions helped states and territories to closely match pre-SSA funding levels in 1937 and 1938, and surpass the pre-SSA funding levels in 1939.

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<sup>67</sup>Maternal and Child Health Bureau. *Celebrating 65 years of Title V*, 24; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>68</sup> Committee on Economic Security. *Social Security in America*. Washington, DC: US Government Printing Office, 1937, 284.

<sup>69</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" United States Committee on Economic Security. *Social Security in America*., 285.

<sup>70</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" Rockwood to Kilpatrick, December 21, 1939, 5, File 14-2-5(0), Box 940, RG 102, NARA.

Table 10. Federal Appropriations for State and Territorial CCS Programs including the District of Columbia with Approved State Plans, 1936-1940

	1936*	1937	1938	1939	1940
Approved State Plans	38	45	50	51	52
Federal Payments to CCS programs	\$732,000	\$2,011,000	\$2,691,000	\$2,997,000	\$3,378,000
Percentage increase from Previous Year	N/A	57%	25%	10%	11%

*Source:* "Federal Funds Paid to States for Services for Crippled Children under the Provisions of Title V, Part 2, of the Social Security Act; Fiscal years 1936-1940, Inclusive," Folder 14-2-5(0), Box 940, RG 102, NARA.

\*Only five months of funding during this year.

Table 11. Federal and State-Level Funding for Services for Crippled Children, 1934, 1937-1939

	1934	1937**	1938	1939
State Funds	\$5,500,00*	\$2,580,000	\$2,455,000	\$2,866,000
Federal Funds	\$0	\$2,011,000	\$2,691,000	\$3,378,000
<b>Total</b>	<b>\$5,500,000</b>	<b>\$4,591,000</b>	<b>\$5,146,000</b>	<b>\$6,244,000</b>

*Source:* Rockwood to Kilpatrick, December 21, 1939, 5, File 14-2-5(0), Box 940, RG 102, NARA.

\*This number reflects an estimate of all 35 state-level crippled children's programs that provided public state funding in 1934. Only twenty-three programs actually provided data on state-level funding to the United States Children's Bureau in 1934, for a total \$3.7 million dollars.

\*\* 1937 represents the first full year of funding under the federal CCS program. In 1936, federal CCS funds were only available for a five-month period.

The federal CCS funding also helped states without established services for crippled children to develop such services. Prior to 1935, seventeen states and territories, including the District of Columbia, did not provide public funding for services for crippled children. Federal funding offered these states and territories an opportunity to create services for crippled children where none had been previously provided. In 1936, ten of these seventeen states (59%) received federal CCS funding, totaling \$77,632.61 (\$5.5 million in 2008 dollars) or eleven percent of total federal CCS funds distributed that year.<sup>71</sup> By 1937, thirteen of the seventeen states (76%) received \$272,535.20 in federal funds (\$17.9 million in 2008 dollars), fourteen percent of the total federal CCS funds paid.<sup>72</sup>

Actual services to crippled children expanded in the first five years of the federal program. Table 12 shows data collected from 1936 to 1940 on the various services provided by all state and territorial CCS programs in their quarterly reports to the USCB. Data collected included information on the following types of services: outpatient clinic care, hospital care, convalescent care, foster home care, home visits and referrals to vocational rehabilitation programs. Services for crippled children provided by states increased across all services from 1936 to 1938, dropped slightly in 1939 and then increased again in 1940. Increased services during the first three years may be accounted for by the steady increase in the actual number of states receiving federal funding. The drop in services in 1939 resulted from changes in the Bureau's reporting requirements. Prior to this time, state CCS programs could report on all services for crippled children in

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<sup>71</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" United States Children's Bureau. *Twenty-fifth Annual Report of the Chief of the Children's Bureau*, 108; United States Department of Labor. *Twenty-fourth Annual Report of the Secretary of Labor*, 116.

<sup>72</sup> *Ibid.*

their states, even services privately funded. Effective January 1, 1939, state CCS programs reported only on those services under their direct control and financing. This resulted in fewer services for crippled children being reported in 1939, but the Bureau wanted data only on services being supported with federal funding.<sup>73</sup>

Unfortunately, national data about services for crippled children prior to 1935 is limited. Most available data reflected the number of state-level institutions, agencies or other facilities serving crippled children. As discussed in Chapter 2, the number of facilities and agencies serving crippled children increased throughout the United States during the early twentieth century, but little comprehensive data was gathered about actual services to crippled children. An official report submitted to the 1930 White House Conference on Child Health and Protection noted that an estimated 125,000 outpatient orthopedic clinic visits were provided to crippled children in 1929, but this estimate was based upon “a partial list of clinical centers and rural clinics.”<sup>74</sup> As can be seen in Table 12, forty-five states reported providing 193,404 outpatient clinic visits in 1937, and by 1940, fifty-one state and territorial CCS programs provided 197,736 clinic visits.

Some individual states did collect and report data related to services provided by their crippled children’s programs prior to 1935. For example, the Michigan Crippled Children’s Commission reported that 3,357 children received services at orthopedic clinics in 1930.<sup>75</sup> By 1939, over 11,681 Michigan crippled children received treatment at

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<sup>73</sup> Hood to Lewan, February 19, 1940, 1, Folder 14-2-7, Box 941, RG 102, NARA.

<sup>74</sup> White House Conference on Child Health and Protection. *The Handicapped Child*, 180.

<sup>75</sup> Upson, Lent Dayton, Opal V. Matson, and Harold Hunter Emmons. *Crippled Children in Michigan: A Study of Their Care, Maintenance and Education*. Detroit, MI: Courier-Berghoff, Inc, 1931, 85; Myers to Hood, June 26, 1940, “State tables of CC Activities Reported for 1939,” 2, Folder 14-2-7(0), Box 941, RG 102, NARA.

Table 12. Services Provided under the Federal CCS Program, 1936-1940

	1936*	1937	1938	1939	1940
Number of CCS Programs with Federal Funds	38	45	50	51	52
Number of Outpatient Clinic Visits provided	43,269	193,404	268,786	196,418	197,736
Number of Children in Hospital Care during the year	13,147	42,346	49,308	41,728	41,625
Number of Children in Convalescent Care during the year	2,122	5,358	6,751	6,545	6,806
Number of Public Health Nurse Visits	31,417	202,351	243,463	197,591	207,108
Number of Physical Therapist Visits	19,298	189,147	343,122	186,436	199,426
Admissions to Medical Social Service	N/A	9,461	18,296	15,073	16,394

*Sources:* Winslow to Hood, "Memorandum," July 16, 1937, 1, Folder 14-2-7(0), Box 941, RG 102, NARA; "Crippled Children on State Registers and Services for Crippled Children, Reported by Official State Agencies Administering State Plans Under the Social Security Act, Title V, Part 2, Calendar Years 1937 and 1938," May 29, 1939, Folder 14-2-7(0), Box 941, RG 102, NARA; Yerushalmay to Daily and Van Horn, "Reports on CC-51 and CC-52 for the Calendar Years 1939, 1940, and 1941," June 4, 1942, 2, Folder 14-2-7(0), Box 290, RG 102, NARA.

\*Only five months of services provided during this year.

orthopedic clinics. The Kansas Society for Crippled Children, an affiliate of the ISCC, reported seeing 659 crippled children at their clinics in 1929 and 541 in 1930.<sup>76</sup> In 1939, the Kansas Crippled Children's Commission recorded 1,502 children were served at outpatient orthopedic clinics that year.<sup>77</sup> Data from Alabama showed similar increases in outpatient visits, from 2,026 children seen at clinics from 1926 through 1928 to 2,810 children seen in 1939 alone.<sup>78</sup> It is difficult to draw definitive conclusions from these comparisons. Data collected by state agencies and groups prior to SSA did not have consistent reporting guidelines and did not include all crippled children living in the state. However, the figures do show a general trend toward increased numbers of crippled children receiving services after 1935.

A few limitations affected the growth of the federal CCS program during its early years. Some state governments were initially unable to match the federal funds, thus limiting the amount of federal money they received for their CCS programs. Table 13 lists all nineteen states that had difficulty matching the required \$20,000 (\$1.3 million in 2008) federal CCS grant in 1937. Thirteen states were able to provide only partial matching funds and six states were unable to provide any matching funds at all.<sup>79</sup> Eight of these nineteen states (42%) did not provide public funding for services for crippled children prior to the SSA, compared to eleven of the thirty-two states (34%) that did match federal CCS funding in 1937. Of the thirteen states that partially matched federal

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<sup>76</sup> Kansas Crippled Children's Temporary Commission. *Report of the Kansas State Crippled Children's Temporary Commission*. Topeka, KS: State of Kansas, 1931, 42; Myers to Hood, June 26, 1940, "State tables of CC Activities Reported for 1939," 2, Folder 14-2-7(0), Box 941, RG 102, NARA.

<sup>77</sup> Myers to Hood, June 24, 1940, "State tables of CC Activities Reported for 1939," 2, Folder 14-2-7(0), Box 941, RG 102, NARA.

<sup>78</sup> The Alabama Society for Crippled Children, "Annual Report of the Alabama Society for Crippled Children," 1929, 2, Folder 65, Box SG006938, Public Information General Files, ADAH; Myers to Hood, June 24, 1940, "State tables of CC Activities Reported for 1939," 2, Folder 14-2-7(0), Box 941, RG 102, NARA.

<sup>79</sup> United States Children's Bureau, *Services for Crippled Children under the Social Security Act*, 42.

CCS funds in 1937, five states (38%) did not appropriate funds for crippled children's programs prior to the SSA. Eight of these states (61%) did provide public funds for services to crippled children before the SSA, but only one state provided more than \$20,000 dollars in funding. Of the six states not matching any federal funding in 1937, three (50%) were states that had no services for crippled children prior to the SSA. These six states were not eligible to draw federal funding in 1937 as they lacked an approved state plan for services for crippled children.<sup>80</sup> With a few exceptions, these numbers suggest that states initially unable to match federal CCS funds, typically did not provide services for crippled children prior to 1935, or did so with small public appropriations.

By 1940, all state and territorial CCS programs were able to meet or exceed the required federal matching grant.<sup>81</sup> Some states needed time to develop state-level legislation, policies, and other types of infrastructure needed to establish programs for crippled children from scratch or very limited resources. Economic conditions also improved during the mid-1930s, and overall spending by states and territories increased across the country.<sup>82</sup> Additionally, the USCB leaders used supplementary funding provided under the SSA Amendments of 1939 to make an extra \$1 million (\$66 million in 2008 dollars) of non-matching funds available to states in need.<sup>83</sup>

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<sup>80</sup> United States Children's Bureau. *Twenty-Fifth Annual Report of the Chief of the Children's Bureau*, 107-108.

<sup>81</sup> United States Department of Labor. *Twenty-Eighth Annual Report of the Chief of the Children's Bureau*. Washington, DC: Government Printing Office, 1940, 175.

<sup>82</sup> Patterson, James T. "The New Deal and the States." *The American Historical Review* 73, no. 1 (1967): 70-84.

<sup>83</sup> United States Children's Bureau, *Services for Crippled Children under the Social Security Act*, 41.

Table 13. Data on State and Territorial CCS Programs Not Matching Federal Funds in 1937

	Percentage of Federal CCS Funding Matched in 1937	Amount of Public Funding for Crippled Children's Programs in 1934
Kansas	80%	\$5,000
Montana	80%	\$13,209
South Carolina	80%	\$10, 112
Alabama	75%	\$5,000
Hawaii	75%	\$0
New York	70%	\$1,135,976
Vermont	70%	\$3,000
North Dakota	40%	\$0
Mississippi	35%	\$17,500
Rhode Island	30%	\$0
Alaska	20%	\$0
New Hampshire	20%	\$3,000
Georgia	15%	\$0
Arkansas	0%	\$9,250
Connecticut	0%	\$84,000
Delaware	0%	\$0
Louisiana	0%	\$0
Nebraska	0%	\$0
Oregon	0%	Not Reported

Source: United States Children's Bureau, *Services for Crippled Children Under the Social Security Act*, 42; Committee on Economic Security. *Social Security in America*, 285.

Another limitation of the federal CCS program was an initial failure to provide states and territories with financial support to expand services for children who had non-orthopedic conditions or chronic illnesses. While state and territorial CCS programs could provide services for all types of crippling and disabling conditions among children, the financial costs of such services restricted the states' ability to provide adequate services to all crippled children in need.<sup>84</sup> For several years, the Advisory Committee on Services for Crippled Children encouraged the USCB to increase funding for services to children suffering from cardiac conditions. The SSA Amendments of 1939 included funding for the federal CCS program to create new services through demonstration projects proposed by the states and territories.<sup>85</sup> In 1940, the USCB funded nine demonstration projects to serve children suffering from rheumatic heart fever. By 1943, fourteen state cardiac programs for children existed and the USCB sponsored its first national conference on rheumatic heart conditions among children.<sup>86</sup>

#### *Improvement of State-Level CCS Programs*

The second major goal of the federal CCS program was to improve the quality of services provided to crippled children at state and local levels. During the initial years of the program, USCB leaders worked to improve services by creating standards for professional personnel employed within the state programs and standards of care for the facilities providing services to crippled children. Additionally, the Bureau established training programs for physicians, nurses, medical social workers, and physical therapists

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<sup>84</sup> United States Children's Bureau, *Services for Crippled Children under the Social Security Act*, 41.

<sup>85</sup> United States Children's Bureau. *Grants to States for Maternal and Child Welfare, Under the Social Security Act of 1935 and the Social Security Act Amendments of 1939, Title V, Parts 1, 2, and 3, Maternal and Child-Health Services, Services for Crippled Children, Child-Welfare Services*. Publication No. 253. Washington, DC: Government Printing Office, 1940, 24.

<sup>86</sup> United States Children's Bureau. *Proceedings of Conference on Rheumatic Fever, Washington, DC, October 5-7, 1943*. Bureau Publication No. 308. Washington, DC: US Government Printing Office, 1945, vii.

interested in working with crippled children. By 1940, the Bureau developed minimal acceptable standards of care for hospitals, convalescent homes, and foster care homes; and standards of minimal qualifications for professional personnel in CCS administrative programs. The Children's Bureau also initiated training programs for state and territorial CCS staff members.

*Standards for Medical and Social Work Personnel.* To develop qualifications for professional personnel in state-level CCS programs, the Bureau relied on assistance from its Advisory Committees and national professional organizations such as American Association of Medical Social Workers (AAMSW), the National Organization of Public Health Nurses (NOPHN), and the ASTHO.<sup>87</sup> The USCB encouraged states to establish standards for state directors, surgeons, public health nurses, medical social workers, and physical therapists employed by state-level CCS programs or CCS contractors. For example, in October 1936, the Advisory Committee on Services for Crippled Children endorsed standards for medical social workers employed in state-level programs developed by the AAMSW for the USCB. The AAMSW recommended that social workers employed in state and territorial CCS programs have previous experience in a medical social work setting and some professional education at a school of social work that was a member of the American Association of Schools of Social Work (the national accreditation body for social work educational programs in the United States during at that time).<sup>88</sup> While the USCB did not require that professional personnel standards be

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<sup>87</sup> Fitzpatrick, M. Louise. *The Nation Organization for Public Health Nursing, 1912-1952: Development of a Practice Field*. New York, NY: National League for Nursing, 1975, 118-119; Stites, Mary A. *History of the American Association of Medical Social Workers*. Washington DC: American Association of Medical Social Workers, 1955, 34.

<sup>88</sup> "Qualifications of Medical Social Workers in Crippled Children's Programs," May 1936, Folder 476, Box 42, American Association of Medical Social Workers, SWHA.

implemented during the early years of Title V, state and territorial CCS programs took the recommendations seriously. By 1938, nineteen state CCS programs (38%) had officially adopted the AAMSW standards for medical social workers.<sup>89</sup> Similarly, the Bureau's Advisory Committee on Services for Crippled Children recommended all orthopedic surgeons employed by the state-level CCS agencies have certification from the American Board of Orthopedic Surgery. By 1939, 24 state CCS programs (48%) required this certification of their surgeons.<sup>90</sup>

Table 14 shows the number of professionals employed in state-level CCS programs that met national professional standards recommended by the USCB. Increases in the number of qualified personnel can be seen for all professions from 1938 to 1939 with further increases in 1940 for medical social workers, physical therapists, and physicians as state directors. States and territories employed fewer numbers of surgeons and public health nurses in 1940 than in previous years.

One possible reason for this decline in the numbers of professional employed by state-level CCS program in 1940 could be the onset of World War II in 1939. Although the United States would not enter the war until December 1941, two factors may have influenced the early mobilization of medical professionals into the war effort. First, many civilian doctors joined the Medical Reserve Corps during the years of the Great Depression as way to earn a part-time paycheck.<sup>91</sup> The Medical Reserve Corps, one of the first military reserve units in United States, was created in 1908 to ensure trained

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<sup>89</sup> Hood to Eliot, "Information Requested for Subjects to be discussed with Dr. Jackson Davis," June 10, 1938, Folder 14-2-1, Box 936, RG 102, NARA.

<sup>90</sup> Hood to Eliot, "Information Requested for Subjects to be discussed with Dr. Jackson Davis," 1, Folder 14-2-1(0), Box 936, RG 102, NARA; United States Children's Bureau, *Services for Crippled Children Under the Social Security Act*, 2.

<sup>91</sup> Cowdrey, Albert E. *Fighting For Life: American Military Medicine in World War II*. New York, NY: Simon and Schuster, 1998, 12.

medical personnel were available for mobilization during times of war. Most of the physicians in the Medical Reserve Corps were called to service as the country mobilized for war in 1940. Second, President Roosevelt signed the Selective Training and Service Act into law on September 16, 1940, establishing the first peacetime draft in the country's history.<sup>92</sup> While physicians were exempt from the new draft, many participated in medical examinations of the new draftees, or volunteered for service following the attack on Pearl Harbor in December 1941. An estimated 60,000 physicians left civilian practice during this time, and the most depleted specialties during the war included surgery, pediatrics and orthopedics, all specialties that cared for crippled children.<sup>93</sup>

Another factor influencing the number and type of personnel employed in state CCS programs during the late 1930s was the lack of qualified professionals present in some parts of the country. This was especially true in rural states or states without crippled children's programs prior to 1935. To help states and territories without qualified professionals, the USCB provided funds to train personnel in specialized orthopedic or other clinical skills. Examples included orthopedic or physical therapy training for physicians and public health nurses, and advanced training in working with crippled children for medical social workers and physical therapists.

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<sup>92</sup> Clifford, John Garry, and Samuel R. Spencer. *The First Peacetime Draft*. Lawrence, KS: University Press of Kansas, 1987.

<sup>93</sup> "Work of Civilian Physicians During World War II." *The Journal of the American Medical Association* 134, no. 4 (1947): 366.

Table 14. Number of Qualified Professionals Employed by State and Territorial CCS Programs including the District of Columbia, 1937-1940

	1937	1938	1939	1940
Number of Programs with Federal Funds	45	50	51	53
Physicians as State Directors	23	29	33	35
Surgeons	N/A	392	800	722
Public Health Nurses	N/A	351	419	359
Medical Social Workers	N/A	34	44	49
Physical Therapists	N/A	48	82	95

*Sources:* United States Children's Bureau Annual Reports, 1937-1940.

State-level CCS programs began training programs as early as 1937 with the goal to educate nurses and physical therapists employed by state-level CCS programs in orthopedic work with crippled children.<sup>94</sup> Within a year, state and territorial CCS programs provided advanced clinical training in the care of crippled children to public health nurses in twenty-four states; medical social workers in five states; physical therapists in two states; and primary care physicians in seven states.<sup>95</sup> The USCB also recognized the need to help develop qualified personnel to work with crippled children, and began directly supporting training efforts for individual professionals working for state CCS programs. In 1939, the USCB provided financial support to seventy-three professionals already employed by state-level CCS programs to receive post-graduate training in orthopedic nursing, public health nursing, physiotherapy, and medical social work.<sup>96</sup> While USCB staff members worked closely with universities and colleges to develop curriculum and training programs for students interested in working with crippled children, these efforts were not financially supported by states or USCB until after World War II.<sup>97</sup> By 1949, the USCB provided training grants to twenty-one different educational centers in an effort to recruit medical, nursing, and social work students to work in state-level CCS programs upon graduation.<sup>98</sup>

The 1939 Amendments to the SSA also required states to improve the qualifications of CCS personnel. The amendments required states and territories to

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<sup>94</sup> United States Children's Bureau, *Twenty-fifth Annual Report of the Chief of the Children's Bureau*, 103.

<sup>95</sup> United States Children's Bureau, *Twenty-sixth Annual Report of the Chief of the Children's Bureau*. Washington, DC: US Government Printing Office, 1938, 130.

<sup>96</sup> United States Children's Bureau, *Services for Crippled Children Under the Social Security Act*, 22.

<sup>97</sup> United States Department of Labor. *Twenty-Eighth Annual Report of the Chief of the Children's Bureau*. 174.

<sup>98</sup> Hutchins, Vince L. "Maternal and Child Health Bureau: Roots." *Pediatrics* 94, no. 5 (1994): 695-699; Federal Security Agency. *Annual Report of the Federal Security Agency, 1949*. Washington, DC: Government Printing Office, 1949, 162.

establish state-level merit employment programs for all personnel, including professionals employed in CCS programs, in order to continue receiving federal support for their SSA programs.<sup>99</sup> The requirement of state-level merit systems was excluded from the original 1935 SSA because members of Congress did not want the federal government interfering with the administration of state-level programs. In 1938, the Social Security Board, the federal agency responsible for administration of financial public assistance programs under the SSA, recommended the re-consideration of state-level merit systems in a report to the President due to “the bad experiences of several states in the political use of public assistance records and the political appointment of personnel.”<sup>100</sup> Members of Congress appeared more supportive of state merit systems in 1939, possibly because nineteen states (37%) had developed merit systems by that time. The requirement to establish state-level merit systems was included in 1939 Amendments which passed the House on June 10, 1939 by a vote of 364 to 2, and the Senate on June 13, 1939 by a vote of 57 to 8.<sup>101</sup> When the President signed the Amendments into law on August 11, 1939, he remarked “probably the most important change that has been made is to require that State agencies administering any part of the Social Security Act coming within the jurisdiction of the Social Security Board and the Children's Bureau shall set up a merit system for their employees.”<sup>102</sup>

USCB leaders actively promoted the merit system believing “the establishment of recommended qualification and standards...in the employment of personnel has been to

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<sup>99</sup> United States Children's Bureau. *Grants to States for Maternal and Child Welfare Under the Social Security Act of 1935*, 9.

<sup>100</sup> Altmeyer, Arthur Joseph. *The Formative Years of Social Security*. Madison, WI: University of Wisconsin Press, 1966, 98.

<sup>101</sup> Social Security History, “Vote Tallies: 1939 Amendments,” Social Security Administration, <http://www.ssa.gov/history/tally1939.html>.

<sup>102</sup> Social Security History, “Presidential Statement on Signing Some Amendments to the Social Security Act --August 11, 1939,” Social Security Administration, <http://www.ssa.gov/history/fdrstmts.html#1939b>.

emphasize the quality of care.”<sup>103</sup> The Bureau required all state plans submitted after January 1, 1940, the date required by the 1939 Amendments, to include some form of a merit system.<sup>104</sup> Under this requirement, state and territorial CCS programs established their own standards for professional and administrative personnel and then hired only individuals that met those standards. Personnel already employed in state CCS programs that did not meet the new qualifications were “grandfathered in” with the understanding that they would complete training programs. By January 1940, nineteen states had already established civil services programs, nineteen state Title V programs were developing merit systems with other SSA programs within their states, and fourteen other Title V programs were establishing merit systems for a single agency.<sup>105</sup>

The USCB’s efforts to improve professional standards affected the practice of medical social work during the late 1930s. In 1937, Edith Baker, a medical social worker from St. Louis, Missouri, became Medical Social Work Consultant for the Crippled Children’s Division of the USCB. Baker, who was the former President of the AAMSW (1921-1931), had worked with the Bureau’s Advisory Committee on Services for Crippled Children to develop the medical social work qualifications recommended by the AAMSW, and the Bureau wanted her to implement these standards from the federal level. While the USCB already employed social workers in its Child Welfare and Research Divisions, Baker was the first medical social worker employed by the Bureau. She recognized the importance of integrating public health skills, such as the use of epidemiology, prevention, and community-based planning and evaluation, into medical

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<sup>103</sup> Hood to Crothers, December 8, 1939, 2, Folder 14-2-0-2-1, Box 936, RG 102, NARA.

<sup>104</sup> United States Children's Bureau. *Grants to States for Maternal and Child Welfare Under the Social Security Act of 1935*, 10.

<sup>105</sup> Hall to Deutsch, May 1, 1940, 1, Folder 14-2-0-2-1, Box 936, RG 102, NARA.

social work practice. This represented a new departure for the field of medical social work, which had primarily focused on social casework practice in hospital and outpatient clinic settings prior to the 1930s. Public relief programs in the early 1930s and the subsequent public health and social welfare programs of the SSA offered medical social workers opportunities to help develop new health care programs, facilitate communication between medical and social welfare programs, and to participate in research and educational programs in state health departments.<sup>106</sup> By the early 1940s, leaders in medical social work practice recommended the inclusion of public health curriculum in educational programs for medical social work students.<sup>107</sup> Additionally, Baker pushed state and territorial CCS agencies to hire medical social workers not only to provide direct services to crippled children, but also to participate in state-level program planning and to promote cooperation among state agencies and groups offering services to crippled children.

With Baker's influence at the USCB, the practice of medical social work in state CCS programs began to incorporate new roles for individual social work practitioners and for the state-level CCS programs.<sup>108</sup> Primary job functions included consultation within and outside of the state CCS program, interdisciplinary planning and coordination for direct services, supervising volunteers, program planning and development, and health education.<sup>109</sup> While social work practitioners employed in state-level CCS

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<sup>106</sup> Grant, Irene. "Medical Social Work." In *Social Work Year Book, 1937*, edited by Russell H Kurtz, 272-276. New York, NY: Russell Sage Foundation, 1937, 274.

<sup>107</sup> Bartlett, Harriett M. "Responsibilities Facing Medical Social Workers Today." *Bulletin of the American Association of Medical Social Workers* 15, no. 5 (1942): 59-64; Ferguson, Grace. "Medical Social Work in the Next Decade." *Bulletin of the American Association of Medical Social Workers* 14, no. 5 (1941): 69-72.

<sup>108</sup> Baker, Edith M. "Some Social Aspects of State Programs of Services for Crippled Children." *The Child* 1, no. 12 (1937): 13-14.

<sup>109</sup> Ball, Georgia. "Clinic Service for Crippled Children: The Medical Social Work in a State Crippled children's program." *The Child* 4, no. 11 and 12 (1940): 296-299; Toland, Marjorie. "The Medical Social

program worked with crippled children and their families as needed, they devoted a majority of their time to community-level activities. Examples of social work tasks with individual crippled children included: 1) health education and counseling of the child and family; 2) social planning (also known as discharge and case planning); 3) accessing resources for the child and family; 4) educating medical personnel about social issues related to the child; and, 5) monitoring the child's rehabilitation. Examples of community-level activities included consultation and coordination. These were two new roles for medical social workers.<sup>110</sup> In a consultation capacity, social workers served as liaisons to public welfare departments, hospital social services, and other public health professionals and clients, and strengthened the integration of welfare and health services. In coordination, social workers helped to organize community efforts in developing and maintaining services for crippled children in local communities without medical services. Consultation and coordination became key roles for social workers in public health settings during the 1950s and 1960s.<sup>111</sup>

The federal CCS program also influenced the spread of medical social work within the USCB. When the Title V programs started in 1935, only the CCS program

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Work in a State Crippled Children Program." *Bulletin of the American Association of Medical Social Workers* 17, no. 4 (1944): 33-37.

<sup>110</sup> Hall, Beatrice. "The Role of Medical-Social Service in the Public-Health Program." *The Child* 9, no. 8 (1945): 127-1930.

<sup>111</sup> Council on Social Work Education. *Public Health Concepts in Social Work Education: Proceedings of Seminar Held at Princeton University, Princeton, N.J. March 4-9, 1962*. New York, NY: Council on Social Work Education, 1962; Committee on Professional Education. "Educational Qualifications of Social Workers in Public Health Programs." *American Journal of Public Health* 52, no. 2 (1962): 317-324; Insley, Virginia. "Social Work Consultation in Public Health." In *Concepts of Mental Health and Consultation: Their Applications in Public Health Social Work*, edited by Gerald Caplin, 215-246. Public Health Service Publication No. 2072. Washington, DC: United States Department of Health, Education, and Welfare, 1959; Rice, Elizabeth P. "Social Work in Public Health." *Social Work* 4, no. 1 (1959): 82-88.

employed medical social workers, at both the state and federal levels.<sup>112</sup> It is unclear exactly why this division occurred, but as medical social workers served crippled children in hospitals and outpatient clinics prior to the SSA, their inclusion in the federal CCS program was a natural fit.<sup>113</sup> In 1941, the Children's Bureau combined its MCH and CC Divisions into one administrative unit, the Division of Health Services.<sup>114</sup> As a result, medical social work services were expanded to MCH programs at both the federal and state-levels.

*Standards for Facilities.* Along with improving personnel qualifications, the USCB also worked to establish standards of care for hospitals and other facilities providing services under state-level CCS programs. These facilities contracted directly with state-level CCS programs to provide services to crippled children.<sup>115</sup> The Bureau's four Advisory Committees (the General Advisory Committee on Maternal and Child Welfare Services, the Advisory Committee for Maternal and Child Health, the Advisory Committee on Services for Crippled Children, and the Advisory Committee on Community Child Welfare Services) had been recommending standards for hospitals and other medical care facilities since 1935. In 1938, the Bureau surveyed the membership of the ASTHO regarding the quality of facilities for maternal health care, and found that

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<sup>112</sup> Cheek, *Martha May Eliot Interview*, 8; Eliot, Martha M. "Foreword." In *Medical Social Services for Children in the Maternal and Child Health and Crippled Children's Programs*, iii-v. Washington, DC: US Government Printing Office, 1953, iv.

<sup>113</sup> Baker, Edith M. "Opportunities for Social Service in an Orthopedic Clinic." *Journal of Bone and Joint Surgery* 2 (1918): 2-16, 34-41; Cannon, Ida M, "The Relation of Hospital Social Service to Child Health Work," In *Proceedings of the National Conference of Social Work at the 48th Annual Session Held in Milwaukee, Wisconsin, June 22-29, 1921*, 179-181, Chicago, IL: The University of Chicago Press, 1921.

<sup>114</sup> Lenroot to Division Directors, August 23, 1941, 1, Folder 1-2-15, Box 692, RG 102, NARA.

<sup>115</sup> Lenroot to Eliot, June 29, 1935, 1, Folder 14-1-0-5, Box 626, RG 102, NARA.

only two of the 50 state health officers (4%) reported adequate medical facilities in their states.<sup>116</sup>

The best available standards of hospital care at the time had been developed in 1917 by the American College of Surgeons (ACS), a professional medical society.<sup>117</sup> The Advisory Committee on Services for Crippled Children recommended that all state-level CCS programs adopt the ACS hospital standards plus several additional requirements that addressed the needs of crippled children. These additional requirements included the employment of qualified surgeons, nurses, physical therapists, and social workers trained in orthopedic care, and the availability of specialized medical equipment for children receiving treatment for their crippling conditions.<sup>118</sup> While the USCB encouraged states to adopt the Advisory Committee's hospital standards, it required only that states adopt some form of standards for hospital care in their programs. By 1938, twenty-five states had adopted the Advisory Committee's standards for hospital care in their CCS programs, and in 1939, ninety percent of all hospitals used by state-level CCS programs met these standards of care.<sup>119</sup> Over the next few years, the Advisory Committee on Services for Crippled Children recommended additional requirements such as separate hospital wards for crippled children, improved documentation on discharge plans and after care, and the inclusion of laboratory facilities

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<sup>116</sup> United States Children's Bureau, *1938 Annual Report*, 115.

<sup>117</sup> Wiener, Carolyn L. *The Elusive Quest: Accountability in Hospitals*. New Brunswick, NJ: Aldine Transactions, 2000, 59-61.

<sup>118</sup> United States Children's Bureau, *Services for Crippled Children under the Social Security Act*, 21-22.

<sup>119</sup> United States Children's Bureau, *1938 Annual Report*, 130; United States Children's Bureau, *Services for Crippled Children under the Social Security Act*, 24.

on-site.<sup>120</sup> The Advisory Committee developed similar standards for convalescent care and foster home care in 1940.

### Conclusion

By 1941, state-level crippled children's programs were well established. The USCB monitored fifty-two programs among all the states and territories, including the District of Columbia. The number and quality of services provided to crippled children across the country improved significantly during the first five years of the federal CCS program. The Bureau utilized new and important innovations to achieve these results such as training programs for professionals working with crippled children, standards of care for hospitals and other facilities for crippled children, and state-level merit systems.

However, as the United States began preparing for World War II in 1940, many state-level CCS programs saw the rapid deployment of key medical, nursing, and social work professionals from these programs into the military and other essential war-effort positions.<sup>121</sup> State and territorial CCS programs continued to serve crippled children during the war, but services were reduced. In 1942, the USCB noted that the overall number of crippled children under care of state-level CCS programs dropped for the first time since the federal CCS program started in 1935.<sup>122</sup> Services to crippled children continued to decline throughout the war, even when the Children's Bureau expanded services to address the needs of working mothers and military families.<sup>123</sup> In 1943, the

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<sup>120</sup> United States Children's Bureau, "Recommendations of the Children's Bureau Advisory Committee on Services for Crippled Children, December 1935-April 1946," MCH Library.

<sup>121</sup> Baker to Daily, "Report of Medical-Social Services in the MCH and CC Program for the Fiscal Year 1942," July 29, 1942, 3, Folder 1-3-1-24, Box, 693, RG 102, NARA.

<sup>122</sup> United States Department of Labor. *Thirtieth Annual Report of the Secretary of Labor*. Washington, DC: Government Printing Office, 1942, 27.

<sup>123</sup> Lindenmeyer, Kriste. "Winning the War but Losing the Peace: The US Children's Bureau and Child Welfare during World War II." *Queen City Heritage: The Journal of the Cincinnati Historical Society* 54, no. 2-3 (1996): 34-47.

Bureau began implementation of the Emergency Maternity and Infancy Care (EMIC) program that provided medical care to soldiers' wives and young children through state health agencies and hospitals. Collaboration did take place between state-level CCS and EMIC programs, but it was not enough to increase the number of crippled children served by state and territorial CCS programs. Only when World War II ended in 1945 did services to crippled children under the federal CCS program increase again.<sup>124</sup>

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<sup>124</sup> United States Department of Labor. *Thirty-Fourth Annual Report of the Chief, Children's Bureau to the Secretary of Labor*. Washington, DC: Government Printing Office, 1946, 83.

## CHAPTER 6

### CONCLUSION

“Handicapping conditions may not be entirely preventable, but thanks to the legacy of the Crippled Children component of Title V of the Social Security Act, the State of Connecticut, as with the Nation, is equipped to cope.”

Saro Palmeri, MD, MPH

Chief of the Health Services for Handicapped Children Section  
Connecticut Department of Health Services<sup>1</sup>

During the war years (1941-1945), the federal government created new social welfare programs to address the needs of civilians and military families. The Community Facilities Act of 1941 (also known as the Latham Act) created day care centers and recreational facilities for the children of working mothers; the Office of Community War Services was established in 1943 to support states and territories in the provision of health, housing, and recreational services to communities affected by the war and defense industries; and the Emergency Maternity and Infancy Care (EMIC) program gave medical care to the wives and young children of unlisted soldiers.<sup>2</sup> Throughout the war, United States Children’s Bureau (USCB) continued to advocate for the needs of the “whole child.” However, Kriste Lindenmeyer suggested the Bureau’s influence and role as the nation’s advocate for children was in decline during the war, in part, due to programs like the Crippled Children’s Services (CCS) and the EMIC that served only

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<sup>1</sup> Palmeri, Saro. “Fifty Years of Service to Handicapped Children.” *Connecticut Health Bulletin* 99, no. 2 (1986): 120-122.

<sup>2</sup> Burson, Herbert Isaac. “War and Social Welfare (United States).” In *Encyclopedia of Social Welfare History in North America*, edited by John M. Herrick and Paul H. Stuart, 424-426. Thousand Oaks, CA: Sage Publications Inc, 2005, 425; Lindenmeyer, Kriste. *A Right to Childhood: The US Children’s Bureau and Child Welfare, 1912-1946*. Urbana, IL: University of Illinois Press, 1997, 240.

special groups of children.<sup>3</sup> Emily Abel suggested that the USCB's influence was already changing in the 1930s, perhaps due to the administrative burdens of operating the large Title V grant-in-aid programs.<sup>4</sup>

After World War II, a reorganization of the federal executive branch affected how the Children's Bureau operated the Title V programs. State governments called for more consolidation at the federal level to reduce multiple interactions with many different federal health and welfare agencies.<sup>5</sup> In 1946, the USCB moved from the United States Department of Labor to another cabinet-level department, the Federal Security Agency (FSA). Created under the Reorganization Act of 1939, the FSA became responsible for many federal health and welfare programs such as the United States Public Health Service (USPHS), the Social Security Board, and the Federal Office of Education (FOE).<sup>6</sup> The goal of this reorganization was to improve efficiency and reduce federal administrative expense by consolidating federal agencies with similar functions. It is unclear why the USCB was not part of the 1939 federal reorganization, but it may reflect the positive relationship between Bureau's leaders, Grace Abbott, Katherine Lenroot, and Dr. Martha May Eliot, and the Secretary of Labor, Frances Perkins (1933-1945). These women established a strong working relationship within the Department of Labor that

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<sup>3</sup> Lindenmeyer, Kriste. "Winning the War but Losing the Peace: The US Children's Bureau and Child Welfare during World War II." *Queen City Heritage: The Journal of the Cincinnati Historical Society* 54, no. 2-3 (1996): 34-47, 43.

<sup>4</sup> Abel, Emily K. "Benevolence and Social Control: Advice from the Children's Bureau in the Early Twentieth Century." *Social Service Review* 68, no. 1 (March 1994): 1-19.

<sup>5</sup> Stein, Harold. "The Transfer of the Children's Bureau." In *Public Administration and Policy Development: A Case Book.*, 17-29. New York, NY: Harcourt, Brace & Company, 1952.

<sup>6</sup> "Social Security Administration." In *Government Agencies*, ed. Donald R. Whitnah. Westport, CT: Greenwood Press, 1983, 492; Lindenmeyer, *A Right to Childhood*, 250.

lasted until Perkins was replaced as Secretary of Labor in 1945, following the death of President Roosevelt.<sup>7</sup>

The Children's Bureau transfer to the FSA was difficult for the USCB's staff. The Bureau was administratively housed within the Social Security Administration, a lesser position within the FSA than the Bureau had in the Department of Labor. Bureau Chief Katherine Lenroot was no longer the final authority on the Title V programs, but had to consult with the Administrator of the Social Security Administration and the Commissioner of the FSA for approval of state plans, and to sanction research and demonstration projects.<sup>8</sup> While Secretary Perkins could have asserted such authority at the Department of Labor, she gave Lenroot and Eliot administrative freedom in working with state and territorial agencies on Title V programs. Because of this new placement with the FSA, Lenroot did not attend the FSA's management meetings, and the Bureau wielded less influence with the federal government.<sup>9</sup> Despite these changes, the Children's Bureau did participate in the development of new services for children with mental retardation, anti-delinquency initiatives for juveniles, and comprehensive health care centers for school-aged children throughout the 1950s and 1960s.<sup>10</sup>

The Children's Bureau continued administration of the federal maternal and children health (MCH) and CCS programs until 1969 when all the Bureau's health programs were transferred to the USPHS. From 1946 to 1969, the federal CCS program continued to expand and improve services for crippled children throughout the United

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<sup>7</sup> Pasachoff, Naomi. *Frances Perkins: Champion of the New Deal*. New York, NY: Oxford University Press, 1999, 79, 87-88.

<sup>8</sup> Stein, "The Transfer of the Children's Bureau," 21.

<sup>9</sup> Stein, "The Transfer of the Children's Bureau," 27.

<sup>10</sup> Stuart, Paul H. "Reflections on the Pioneers Listening Conferences: Investment in Social Work After World War II," (2008).

States. Following World War II, the number of crippled children receiving services from state-level CCS agencies increased and surpassed pre-war levels, and more states began developing programs for children with rheumatic heart fever and cerebral palsy.<sup>11</sup> In 1958, state-level CCS programs provided services to 325,000 children (a fifty percent increase from 1937) and orthopedic conditions accounted for less than fifty percent of the crippling conditions addressed by state-level CCS programs.<sup>12</sup> During the 1950s and 1960s, the federal CCS program encouraged states to pay for new diagnostic procedures and treatment technologies for conditions such as epilepsy, hearing impairments, and congenital health disease. As a result, the federal CCS program made significant contributions to the development of pediatric and surgical specialization in the United States.<sup>13</sup>

With the creation of Medicaid in 1965 and the MCH Block Grant in 1981, state-level CCS programs began contracting direct medical and social services with local hospitals and medical providers.<sup>14</sup> The federal CCS program gradually shifted away from providing direct care to children with physical handicaps and their families to developing systems of care and infrastructure that improved medical and social services for children with physical handicaps. Examples of indirect services include the promotion of family-centered care, the development of genetic newborn screening

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<sup>11</sup> Federal Security Agency. *Annual Report of the Federal Security Agency, For the Fiscal Year 1947*. Washington, DC: Government Printing Office, 1948, 127-130.

<sup>12</sup> Lesser, Arthur J. "The Origin and Development of Maternal and Child Health Programs in the United States." *American Journal of Public Health* 75, no. 6 (1985): 590-598.

<sup>13</sup> Ireys, Henry T., Robert J.P. Hauck, and James M. Perrin. "Variability Among State Crippled Children's Service Programs: Pluralism Thrives." *American Journal of Public Health* 75, no. 4 (1985): 375-381.

<sup>14</sup> Lesser, "The Origins and Development of Maternal and Child Health," 594; Ireys, Hauk and Perrin, "Variability Among State Crippled Children's Service Programs," 375.

programs, and improved health insurance coverage for children.<sup>15</sup> Today, the federal CCS program is known as services for Children with Special Health Care Needs (CSHCN), under the MCH Block Grant. In 2009, the CSHCN program supports fifty-nine state and territorial programs, and the combined federal-state contributions budgeted for 2009 totals over \$5 billion dollars.<sup>16</sup> In 2007, over 1.8 million children with special health care needs received services from this program.<sup>17</sup>

### Services for Crippled Children before Federal Funding

Prior to the passage of the Social Security Act (SSA), services for crippled children in the United States included a wide variety of programs, policies, and facilities that developed at the state and local levels. Large cities such as New York City, Cleveland, and Chicago, created a variety of programs for crippled children in response to survey data, clinical experience, and grass roots advocacy efforts by charity and service organizations. Starting in the 1890s, orthopedic and children's hospitals offered some of the first services for crippled children including medical and surgical treatments, physical therapy, and educational services. Over the next forty years, new types of medical and treatment services for crippled children developed such as convalescent care and after care services. The number of programs and facilities for crippled children increased as did the number of children receiving medical treatment, support care, and educational services. Financial support for these services and programs came from many

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<sup>15</sup> Wallace, Helen M., Gordon Green, and Kenneth J. Jaros. *Health and Welfare for Families in the 21st Century*. Sudbury, MA: Jones & Bartlett Publishers, 2003.

<sup>16</sup>Maternal and Child Health Bureau, "Federal and Federal-State Title V Block Grant Partnership Budget Earmarked for Children with Special Health Care Needs," <https://perfdata.hrsa.gov/mchb/mchreports/Search/financial/finsch04.asp>.

<sup>17</sup>Maternal and Child Health Bureau, "Program Data: Number of Individuals Served by Title V, by Class of Individuals," <https://perfdata.hrsa.gov/mchb/mchreports/Search/program/prgsch04.asp>.

sources including state governments, counties, municipalities, patient fees, and private charities.

The surprising growth and increasing diversity of services for crippled children from the late nineteenth century to the 1930s reflected an important grassroots movement in the development of child health programs in the twentieth century. Many child savers, social reformers, and philanthropists including Edgar Allen, Edith Solenberger and Douglas McMurtrie influenced the growth in services for crippled children by raising funds for services and research, campaigning for more and improved services and government legislation, and organizing advocacy groups on behalf of crippled children. By 1934, these efforts raised approximately \$5.5 million (\$493 million in 2008 dollars) in annual state appropriations for crippled children's programs in thirty-seven states.<sup>18</sup> Private funding was an important source of revenue for services for crippled children during this period. In 1929, the Benevolent and Protective Order of the Elks spent \$224,000 (\$12 million in 2008 dollars) on care for crippled children in forty-one states.<sup>19</sup> Additionally, the Association for the Aid of Crippled Children (AACC), a private agency that served crippled children in New York during the early twentieth century, raised \$82,976 (\$5 million in 2008 dollars) for services in 1930.<sup>20</sup>

These are impressive figures for child health programs operating during the Great Depression, and are even more impressive when compared to the work done to fight infant and maternal mortality. In 1934, the USCB reported that thirty-nine state health

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<sup>18</sup> Committee on Economic Security. *Social Security in America*. Washington, DC: US Government Printing Office, 1937, 285; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>19</sup> Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar;" White House Conference on Child Health and Protection. *The Handicapped Child: Report of the Committee on Physically and Mentally Handicapped*. New York, NY: The Century Company, 1933, 157.

<sup>20</sup> Association for the Aid of Crippled Children, "Annual Report, 1930," 1930, 7, Reel 32, *Annual Reports, 1909-1996*, Foundation for Child Development, Microfilm Collection, RAC; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

departments funded Maternal and Child Health (MCH) programs with a combined annual total of \$1.1 million (\$98 million in 2008) in state appropriations.<sup>21</sup> This was a fifty percent drop in public funding for MCH services from 1928, when the Sheppard-Towner Act (STA) provided federal appropriations to state-level MCH services for nearly nine years during the 1920s. In 1928, over a \$1 million dollars (\$58 million in 2008 dollars) in federal funding was matched dollar-for-dollar by forty-six states, totaling \$2 million dollars (\$116 million in 2008 dollars) spent on preventive health care for pregnant women, infants and children.<sup>22</sup> While private charities and public health agencies did support infant and maternal health services in major cities before and after the STA, funding for these programs was small and sporadic.<sup>23</sup> In 1915, public and private agencies operated 539 infant and children health centers throughout the United States, compared to the 2,294 centers that operated in 1929 during the final year of federal funding under the STA.<sup>24</sup> A year later, in 1930, there were only fifteen hundred child health centers still in operation. These numbers suggest that federal funding played a significant role in the development of services to reduce high rate of infant and maternal mortality in the United States during the 1920s.<sup>25</sup>

During the late nineteenth and early twentieth centuries, social reform efforts to address the problems of infant mortality and the needs of crippled children shared a

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<sup>21</sup> *Ibid*, p. 273; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>22</sup> United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy, The Administration of the Act of Congress of November 23, 1921, Fiscal year ended June 30, 1929*. United States Children's Bureau Publications Publication No. 203. Washington, DC: Government Printing Office, 1931, 2-3; Officer and Williamson, "Six Ways to Compute the Relative Value of a U.S. Dollar."

<sup>23</sup> Meckel, Richard A. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*. Ann Arbor, MI: Ann Arbor Paperbacks, 1998, 124.

<sup>24</sup> Committee on Economic Security. *Social Security in America*: 269; Goodwin, Etta A. *A Tabular Statement of Infant-Welfare Work by Public and Private Agencies in the United States*. Infant Mortality Series No.5, Children's Bureau Publication No. 16. Washington, DC: Government Printing Office, 1916; Meckel, *Save the Babies*, 125.

<sup>25</sup> Meckel, *Save the Babies*, 212.

common concern for the welfare of infants and children. But national programs for crippled children's services developed differently compared to maternal and child health programs. While the STA provided federal funding for MCH efforts during the 1920s, advocates for crippled children continued developing medical and social services for crippled children without the help of federal intervention. When Sheppard-Towner funding ended in 1929 and the Great Depression started, many states reduced or eliminated funding for their MCH programs. In comparison, state-level services for crippled children supported by public and private monies maintained relatively high levels of funding without the help of federal support during the early 1930s.

The STA provided valuable lessons for social reformers and health care professionals interested in promoting services for crippled children in the 1930s. Permanent federal funding was essential to expanding the CCS programs to all states. By 1934, without the federal support provided by the STA, nine states (19%) eliminated MCH services, and twenty-nine states (60%) significantly curtailed services.<sup>26</sup> Only ten states (20%) maintained or exceeded the federal and state-matched funding provided under STA. The experience with MCH programs suggested that CCS budgets were also under pressure. While over half the states had established services for crippled children by 1934, many still did not provide financial support for these services. Some states did not have facilities or health professionals to provide the needed medical and social treatment. Edgar Allen and other members of the International Society for Crippled Children (ISCC) recognized that federal intervention was essential to treat and cure all

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<sup>26</sup> Committee on Economic Security. *Social Security in America*, 273; United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy, The Administration of the Act of Congress of November 23, 1921, Fiscal year ended June 30, 1929*. Publication No. 203. Washington DC: Government Printing Office, 1931, 2-3.

crippled children in the United States, and thus strongly advocated for a national program of services for crippled children during the early 1930s. In addition, Grace Abbott, Katherine Lenroot, and other USCB staff members recognized the role organized medical associations played in the demise of the STA in the late 1920s.<sup>27</sup> Fearing similar opposition to child health programs proposed in the SSA, the Bureau leadership strategically included services for crippled children in their proposal, confident that few physicians would publicly contest the need to help children with physical handicaps. Further, they solicited support from orthopedic surgeons and pediatricians for the federal CCS program.<sup>28</sup> The economic crisis of the Great Depression created a political environment that supported the expansion of the federal government and the USCB leadership's recommendation to include services for crippled children in the SSA took advantage of this and proved successful in creating a new era of federal child health programs in the twentieth century.

#### Accomplishments of the Early Federal CCS program

Unlike the earlier MCH programs under the STA, little has been written about the federal CCS program. Even scholarly works on the USCB during the New Deal give less attention to the CCS program than to the MCH program, Aid to Dependent (ADC), and other child welfare programs. The federal CCS program was a relatively small health care program for a very specific population within the larger context of the SSA, even compared to the MCH program. By 1940, states received \$4.8 million for their

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<sup>27</sup> Lemons, J. Stanley. "The Sheppard-Towner Act: Progressivism in the 1920s." *The Journal of American History* 55, no. 4 (March 1969): 776-786.

<sup>28</sup> "Consultation with Group of Orthopedic Surgeons," June 4, 1935, 1-6, Folder 14-0-4, Box 626, RG 102, NARA.

MCH programs and only \$3.3 million for CCS programs.<sup>29</sup> Further, state-level MCH programs provided more services to more children than the CCS program. In 1940, the state-level MCH programs provided outpatient well-child examinations to over 2 million children, and public health nurses in the MCH programs completed over 5 million nursing visits with infants and children.<sup>30</sup> During the same year, state-level CCS programs saw 197,736 crippled children at outpatient clinics, and public health nurses in the CCS programs made over 200,000 nursing visits.<sup>31</sup> Despite the fact that crippled children required more medical and social intervention than average children, these numbers do reflect some of the differences between the MCH and CCS programs.

The inclusion of the CCS program in the original SSA made services for crippled children the one of the first federally financed medical programs for children, and demonstrated an important change in federal approach to MCH care in the United States, particularly for the USCB. No longer focusing on broad social policies for all American children and their mothers, the Bureau became responsible for administering and monitoring a complex health care program for a special class of children -- children with serious orthopedic and medical problems. The Bureau needed to shift focus from its Progressive Era policies that emphasized universalism (serving all children and their mothers) to selectivity (serving a class of children who had particular medical conditions that required care). While the USCB did not define who qualified as a crippled child, the federal CCS program served a much more limited population of children than potentially served by MCH program.

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<sup>29</sup> Maternal and Child Health Bureau, *Celebrating 65 years of Title V: The Maternal and Child Health Program, 1935-2000*, Rockville, MD: US Department of Health and Human Services, 2001, 24.

<sup>30</sup> United States Department of Labor. *Twenty-eighth Annual Report of the Chief of the Children's Bureau*. Washington, DC: Government Printing Office, 1940, 160.

<sup>31</sup> United States Department of Labor. *Twenty-eighth Annual Report*, 172.

During its early years, the federal CCS program did succeed in expanding services to crippled children across the country. By 1941, fifty-two states and territories operated their own CCS programs (up from thirty-seven states in 1934), providing medical and social services to thousands of crippled children in hospitals, outpatient clinics, and convalescent homes.<sup>32</sup> Thousands of crippled children were also identified during the early years of the program, providing important national data on the prevalence of crippled children and improving access to care for crippled children and their families. From 1936 to 1941, the number of crippled children listed on state registries increased from 97,000 to 308,000, indicating success in case finding services, one of the objectives for the CCS program in the SSA.<sup>33</sup> During the 1930s, case finding became an important public health practice used to fight communicable diseases like tuberculosis (TB) or syphilis.<sup>34</sup> By tracking down individuals who had come into contact with a person diagnosed with a communicable disease, public health practitioners identified the disease earlier among individuals and prevented the disease from spreading. While only a few causes of crippling conditions among children were caused by communicable diseases (polio and TB), professionals working in crippled children's programs used case finding as a way to identify these children early in life so as to prevent permanent disability.

Services provided by states to crippled children also increased during the late 1930s and early 1940s. The number of children who received hospital care increased

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<sup>32</sup> United States Children's Bureau. *Twenty-ninth Annual Report of the Chief of the Children's Bureau*. Washington, DC: Government Printing Office, 1936, 112-113.

<sup>33</sup> United States Children's Bureau. *1936 Annual Report*, 118.

<sup>34</sup> Brandt, Allan M. *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*. New York, NY: Oxford University Press, 1987, 150; Lundy, Karen Saucier, Sharyn Janes, and Wanda Dubuisson. *Community Health Nursing*. Boston, MA: Jones & Bartlett Publishers, 2009, 89.

from 13,147 in 1936 to 43,877 in 1941, and the number of outpatient clinic visits rose from 43,269 visits in 1936 to 210,651 in 1941.<sup>35</sup> Additionally, the USCB instituted standards for facilities and health care professionals to improve the quality of care in the state CCS programs, an early example of federal quality improvement efforts for health care facilities. The Bureau later applied these standards to its other MCH programs such as the Emergency Maternity and Infancy Care (EMIC) program during the 1940s.<sup>36</sup>

The federal CCS program had some limitations. Initially, services were restricted to children with specific medical and orthopedic conditions. While the program became more inclusive over time, initially, it did not attempt to extend services to children without medical or orthopedic problems or cover routine pediatric services for sick or disabled children. Furthermore, Emily Abel suggested that families with crippled children had difficulty obtaining services for their children during the early days of the program. In a study of letters written to the USCB during the 1930s, Abel found that parents who had children with physical and mental health problems often had trouble obtaining health care services at the local and state levels. Problems included poor quality of care at state and private facilities, restrictive eligibility requirements for the state and local programs, and issues of racism and segregation.<sup>37</sup> Abel found Bureau staff's response to parents' complaints about state-level services to be minimal and bureaucratic, and the USCB staff offered little direct intervention to remedy reported problems.<sup>38</sup> This appears in sharp contrast to Bureau staff members' communication

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<sup>35</sup> United States Children's Bureau. *Twenty-ninth Annual Report*, 120.

<sup>36</sup> Sinai, Nathan, and Odin W. Anderson. *EMIC (Emergency Maternity and Infant Care): A Study of Administrative Experience*. Bureau of Public Health Economics Research Series No. 3. Ann Arbor, MI: University of Michigan, School of Public Health, 1948.

<sup>37</sup> Abel, Emily K. "Appealing for Children's Health Care: Conflicts between Mothers and Officials in the 1930s." *Social Service Review* 70, no. 2(1996): 282-304.

<sup>38</sup> Abel, "Appealing for Children's Health Care," 293-299.

with parents during the 1910s and 1920s, when staff members responded with personalized letters and direct referrals to state authorities and private agencies.<sup>39</sup>

### Implications for Social Work and Public Health

Insights about the creation and expansion of the federal CCS program in the 1930s can help to inform the policies and practice of today's social workers and public health practitioners. Known today as Children with Special Health Care Needs (CSHCN), the federal CCS program is almost seventy-five years old and has experienced many legislative and policy changes during this time. This study can offer current practitioners an understanding of how and why the initial federal CCS program developed, providing a deeper look at how services for children with physical handicaps changed over time. Further, this study highlights the role played by the social reformers and child health advocates in the early twentieth century, especially the contributions of the USCB. Other scholars have credited the Bureau with laying the foundation for today's Title V programs and policies, establishing the value of strong women's voices in the federal government and linking research with political advocacy on behalf of women and children.<sup>40</sup> Perhaps most important are that the policies and practices revealed in this study that can inform the work of today's social workers and public health practitioners. Two examples include the inquiry-advocacy model promoted by the USCB and the development of public health social work as a unique practice specialty.

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<sup>39</sup> Ladd-Taylor, Molly. *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau*. New Brunswick, NJ: Rutgers University Press, 1986.

<sup>40</sup> Lindenmeyer, A *Right to Childhood*; Muncy, Robyn. *Creating a Female Dominion in American Reform, 1890-1935*. New York, NY: Oxford University Press, 1991.

### *The Inquiry-Advocacy Model*

During the early twentieth century, social reformers and MCH advocates actively promoted and developed the use of inquiry and advocacy into the framework of their policies and programs.<sup>41</sup> Advocates used social science research methods to uncover the facts about the prevalence of problems and the effective solutions to those problems. The USCB designed and conducted research studies on many topics related to the problems of childhood, such as infant mortality, maternal mortality, child labor, and state-level legislation affecting women and children. The USCB used data from numerous studies conducted by Bureau staff and by outside agencies and researchers to promote and endorse state and federal legislation and policy changes in an effort to improve the health and well-being of children and their families. Information from the Bureau's initial studies on infant mortality provided data that helped the Bureau to advocate for the STA of 1921.

The Bureau repeated the model of inquiry and advocacy when drafting the CCS program for the SSA. During the early twentieth century, many private and public agencies conducted studies to describe and understand the needs of crippled children. Examples include Solenberger's *Care and Education of Crippled Children in the United States* (1914), Henry Abt's *The Care, Cure, and Education of the Crippled Child* (1924), and papers from the 1930 White House Conference on Child Health and Protection. These reports, along with studies completed by the USCB, informed the Bureau's recommendation to the Committee of Economic Security (CES) which were subsequently incorporated in the final draft of the 1935 SSA. The federal CCS program provides an

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<sup>41</sup> Bierman, Jessie M. "Advocacy and Inquiry: Their Roles in Development of Health Services for Mothers and Children." *American Journal of Public Health* 56, no. 5 (1966): 720-725.

important example of the inquiry-advocacy model. As an early precursor to today's evidence-based policy practice, the inquiry-advocacy model offers an important exemplar for today's social work and public health researchers. Through the study of social problems and use of findings to advocate for policy change, research is given a purpose that may serve to bridge the gap between researchers and practitioners in the professions of social work and public health.

### *Public Health Social Work*

The early federal CCS program provides significant insight into the development of public health social work as a unique specialty within the professions. Some MCH scholars credited the inclusion of medical social work within federal CCS program as the true beginning of public health social work in the United States.<sup>42</sup> The Bureau recognized the importance of integrating social work and public health skills for medical social workers employed in state-level CCS programs. Public health skills considered integral to social work practice included epidemiology, prevention, and community-based planning and evaluation.<sup>43</sup> Techniques important in social work practice such as consultation and coordination were developed at state-level CCS programs. Medical social workers were also integrated into state-level CCS programs through: 1) federal policy requirements, 2) new opportunities to obtain continuing education and training, and 3) the development of new educational programs at colleges and universities that were supported by the federal CCS program. This three-tiered approach not only helped to develop qualified social workers, it also served to strengthen the profession of social

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<sup>42</sup> Kumabe, Kazuye, Chikae Nishida, David O'Hara, and Charlotte Woodruff. "Historical Perspectives on Maternal and Child Health Services." In *A Handbook for Social Work Education and Practice in Community Health Settings*, 1-9. Honolulu, HI: University of Hawaii School of Social Work, 1977.

<sup>43</sup> Kumabe, et al., "Historical Perspectives on Maternal and Child Health Services," 6.

work. This useful educational and leadership development model from the past may provide new tools to strengthen social work and to recruit professionals to the field.

### Future Research

While this study fills a gap in the literature about child health programs developed in the United States during the New Deal, it suffers from what social welfare Clarke Chambers called a “top-down” bias of social welfare history.<sup>44</sup> This traditional approach to social welfare history relies heavily on the records of the “guardian class” (superintendents and administrators of programs and public or private boards of program and institutions) and focuses on program or policy development. This research does not include stories of social workers or public health practitioners who provided direct services to crippled children nor does it include the perspective of children who received those services or their parents or guardians. Future research into early programs for crippled children would benefit from a “bottom-up” approach by focusing on informal and self-help systems of mutual assistance, the role of volunteers, the direct service practice of social workers, and how issues of race and class have affected the development of CCS programs in the United States.

Additional research from the federal or national perspective could trace the development of the federal CCS program throughout the twentieth century, looking at how program’s development in the late 1930s influenced later development during the cold war years of 1950s and the Great Society years of the 1960s. The influence and development of private groups, such as the Easter Seals Disability Services (formerly the International Society for Crippled Children) and the Shriners Hospitals for Children, over

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<sup>44</sup> Chambers, Clarke A. ““Uphill All the Way”: Reflections on the Course and Study of Welfare History: The Social Service Review Lecture.” *The Social Service Review* 66, no. 4 (1992): 492-504.

the twentieth century could provide insights into the role private charities have played in the development of services for children with disabilities. In addition, the complex and interdisciplinary nature of services for crippled children offers a context for understanding the development of medical, social work, and public health professions during the twentieth century.

Another area for study is the important work done by state CCS agencies following the passage of the SSA in 1935. The SSA gave state agencies significant freedom to develop CCS programs that would meet the needs of children in their jurisdictions. A true assessment of the effectiveness of the federal CCS program should include state-level analyses because funding was determined by state-based plans and state-generated matching funds.<sup>45</sup> Research on how state politics and policies played a role in the development of CCS programs would significantly contribute to the understanding of this New Deal child health program. Important topics to be explored include the development of individual state-level programs under the federal CCS program, especially programs with and without state-based programs for crippled children before 1935; the influence of regional differences on the development of state-level programs; the level and quality of cooperative relationships established between state-level health, education, and welfare agencies; and the role state CCS agencies played in the expansion of services to children with non-orthopedic conditions.

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<sup>45</sup> Ladd-Taylor, Molly. "Federal Help for Mothers: The Rise and the Fall of the Sheppard-Towner Act in the 1920s." In *Gendered Domains: Rethinking Public and Private in Women's History: Essays from the 7th Berkshire Conference on the History of Women, 1987*, edited by Dorothy O. Helly and Susan M. Reverby, 217-227. Ithaca, NY: Cornell University Press, 1992.

### *Conclusion*

Findings from this study contribute to the understanding of how health care programs for children with disabilities developed during the early twentieth century. Factors that led to the creation of the federal CCS program in 1935 included the expansion of federal public health programs that occurred during 1920s, the growth of philanthropic work on behalf of crippled children by private individuals and organizations, and the incidence of polio in the United States during the early twentieth century. Reasons for the inclusion of services for crippled children into the SSA of 1935 consisted of: 1) an increased interest on the part of USCB leaders in services for crippled children during the time; 2) advocacy efforts by private organization such as the ISCC; and 3) the lack of opposition from the organized medical community and the USPHS.

Once established, several influences helped to shape the development of the federal CCS program during the late 1930s and early 1940s. The SSA itself provided specific guidelines about service provision, federal-state program operations, and appropriations. Important examples included the requirements that state-level programs include preventive services and interdisciplinary approaches to service provision. The USCB, as the federal agency administering the CCS program, interpreted the SSA for states agencies and established policies and procedures that affected the development of state-level programs. Examples consist of an open definition for who qualified as a crippled child, the development of national advisory committees, and development of standards for personnel and facilities serving crippled children. Significant state-level characteristics that influenced how individual state programs developed included the availability of matching state funds, the establishment of state programs for crippled

children prior to the SSA, and the accessibility of qualified health care professionals and facilities.

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## APPENDIX A

### RESEARCH METHOD AND SOURCES

Historical research methodology outlined by Leighninger and Stuart provided the research method to address the research questions described in Chapter 1.<sup>46</sup> The specific steps used included:

1. choosing a research question to investigate;
2. gathering evidence which bears on the research question;
3. determining what the evidence means or a synthesis; and
4. writing the report.<sup>47</sup>

Several secondary sources (works of other researchers based on their review of primary evidence) helped in the selection of this study's research question. Secondary sources of evidence are important for understanding gaps in the literature, developing research questions and identifying primary sources.<sup>48</sup> Specifically, these works provided information on the people, groups and events that influenced the development of the federal Crippled Children's Service (CCS) program. While the bibliography listed at the

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<sup>46</sup>Leighninger, Leslie H. "Historiography." In *Encyclopedia of Social Work*, edited by Richard L. Edwards, 1252-1256. 19th ed. Washington DC: National Association of Social Workers, 1995; Stuart, Paul. "Historical Research." In *Social Work Research and Evaluation*, edited by Richard M. Grinnell, 442-457. 5th ed. Itasca, IL: F.E. Peacock Publishers, Inc, 1997.

<sup>47</sup> Stuart, "Historical Research," 445-554.

<sup>48</sup> Stuart, "Historical Research," 455-456.

end of this document provides a complete list of all secondary sources used in this research, a few of these works are discussed here in detail.

Many scholarly works have addressed the lasting impact of the United States Children's Bureau (USCB) on child health programs in the US. Kriste Lindenmeyer's *A Right to Childhood: The US Children's Bureau and Child Welfare, 1912-46* (1997) provided important background information about the United States Children's Bureau (USCB) during its first 30 years, and about the key role the Bureau played in the development of the Title V programs.<sup>49</sup> *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott* (1983) by Lela Costin discussed how Grace Abbott contributed to the development of the federal CCS program.<sup>50</sup> Additionally, an article by Jacqueline Parker and Edward Carpenter in the *Social Service Review* titled "Julia Lathrop and the Children's Bureau: The Emergence of an Institution" (1981) offered insight into the role Julia Lathrop, the first chief of the USCB, played in the formation of the USCB during its early years.<sup>51</sup>

Some sources provided specific information about the development of the federal CCS program. A dissertation by James Henry Conrad titled *Health Services of the United States Children's Bureau, 1935-1953* (1974) offered a detailed discussion of the legislative process involved in the development of the Title V health programs during the 1930s, and specifically about the Maternal and Child Health (MCH) program than the

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<sup>49</sup> Lindenmeyer, Kriste. *A Right to Childhood: The US Children's Bureau and Child Welfare, 1912-1946*. Urbana, IL: University of Illinois Press, 1997.

<sup>50</sup> Costin, Lela. *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott*. Urbana, IL: University of Illinois Press, 1983.

<sup>51</sup> Parker, Jacqueline K., and Edward M. Carpenter. "Julia Lathrop and the Children's Bureau: The Emergence of an Institution." *The Social Service Review* 55, no. 1 (March 1981): 60-77.

CCS program.<sup>52</sup> Two works by Dr. William M. Schmidt, a pediatrician who was prominent in the field of MCH during the 1960s, examined the unique contributions of the federal CCS program to child health care in the United States: 1) “The Development of Health Services for Mothers and Children in the United States” from the book *Maternal and Child Health Practices, 3<sup>rd</sup> Edition*; and 2) “How Children Got into the Act” a paper presented at the 1967 National Conference on Social Welfare.<sup>53</sup> Brad Byrom’s book chapter, “The Progressive Movement and the Child with Physical Disabilities,” (2006) presented a look at reform efforts for crippled children prior to the Social Security Act (SSA).<sup>54</sup>

Other helpful secondary sources provided knowledge about social reform efforts during the early twentieth century and the individuals behind these efforts. Two books on the history of social welfare in the United States, *In the Shadow of the Poor House* (1986), by Michael Katz and *From Poor Law to Welfare State* (1999), by Walter Trattner, provided a broad understanding of the link between social welfare and public health reform efforts, including programs to address problems associated with child health.<sup>55</sup> Clarke Chambers’ discussion of reform efforts prior to the New Deal in *Seedtime of Reform: American Social Service and Social Action, 1918-1933* (1967)

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<sup>52</sup> Conrad, James Henry. “Health services of the United States Children's Bureau, 1935-1953,” Ph.D. diss., The Ohio State University, 1974.

<sup>53</sup> Schmidt, William M. “How Children Got into the Act.” In *Children and Youth in America: A Documentary History*, edited by Robert H. Bremner, John. Barnard, Tamara K. Hareven, and Robert M. Mennel, Volume III, 1933-1973, Parts 5-7:1211-1213. Vol. 1933. Cambridge, MA: Harvard University Press, 1974; Wallace, Helen M., and William M. Schmidt. “The Development of Health Services for Mother and Children in the United States.” In *Maternal and Child Health Practices*, 3-45. Third Party Publishing Company, 1988.

<sup>54</sup> Byrom, Brad. “The Progressive Movement and the Child with Physical Disabilities.” In *Children with Disabilities in America: A Historical Handbook and Guide*, edited by Philip L. Safford and Elizabeth J. Safford, 49-64. Westport Conn.: Greenwood Publishing Group, 2006.

<sup>55</sup> Katz, Michael B. *In the Shadow of the Poorhouse: A Social History of Welfare in America*. New York, NY: Basic Books, 1996; Trattner, Walter I. *From Poor Law to Welfare State: A History of Social Welfare in America*. New York, NY: The Free Press, 1999.

included information about many social reformers and groups.<sup>56</sup> Theda Skocpol's *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (1992) and J. Stanley Lemon's article from *The Journal of American History* titled "The Sheppard-Towner Act: Progressivism in the 1920s" (1969) offered a good overview of the development of the Sheppard-Towner Act (STA) of 1921.<sup>57</sup>

### Approach to Study

Because little has been written about the federal CCS program, the goal was to tell the story from the perspective of the institutions, groups, and individuals who contributed to the program's creation and subsequent development. While many factors potentially contributed to the creation and development of the CCS program, I focused on three main areas to provide a framework for this study: 1) the role of social reformers and professional groups; 2) the role of state-level private charities and children's institutions; and 3) the increasing authority of the federal government in social programs.

Early services for crippled children were developed during the Progressive Era (approximately 1890 to 1920). Progressive reformers promoted humanitarian causes through the development of programs, services, and policy changes. Initially associated with private social welfare agencies and charities, these social reformers advocated for government-led interventions at the state, and then national level. Local and state-level private charities and institutions provided unique advocacy and service provision efforts that pushed the plight of crippled children onto the national reform agenda of the 1930s.

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<sup>56</sup> Chambers, Clarke A. *Seedtime of Reform: American Social Service and Social Action, 1918-1933*. Ann Arbor, MI: The University of Michigan Press, 1967.

<sup>57</sup> Skocpol, Theda. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge, MA: The Belknap Press of Harvard University Press, 1992.

The establishment of the United States Children's Bureau (USCB) in 1912 was an important success of the Progressive movement, and in the later development of the federal CCS program. Progressive Era reformers working at the national level provided essential support, advocacy and oversight to the overall creation and growth of the federal CCS within the larger framework of the SSA. Medical and health care professionals also promoted the expansion of medical and social treatments for crippled children.

Changes in federalism, defined as the division of power between a central government and smaller governing unit, during the early twentieth century also helped inform this study. In the United States, social welfare and public health programs were typically under the jurisdiction of state and local governments while the federal government focused on issues such as international affairs and interstate commerce. During the early twentieth century, the role of the federal government in the areas of health and welfare began to grow, and by the 1930s, New Deal programs greatly expanded federal-state partnerships. The SSA of 1935 represented one of the largest federal interventions to date, and as part of the SSA, the federal CCS program offered states and territories an opportunity to "expand and improve" services for crippled children across the country.

#### Sources

Several archives, libraries, and digital collections supplied the needed primary sources, including printed books and articles and unpublished manuscripts, to complete this research. The National Archives and Records Administration (NARA) in College Park, Maryland, houses the records of the United States Children's Bureau (Record Group 102) and the Records of the Committee on Economic Security (Record Group 47).

Documents from these collections provided data about the development of the Social Security Act and implementation of the federal CCS program by the USCB. The Rockefeller Archive Center (RAC) in Sleepy Hollow, New York holds the records and papers of the charities of John D. Rockefeller and members of the Rockefeller family. The RAC collections provided valuable information about the development of local programs for crippled children prior to the SSA. I used several collections from the RAC including the microfilm collection of the Foundation for Child Development (1909-1996), the Rockefeller Family Archives, and the Rockefeller Foundation Archives. Two collections from the Franklin Delano Roosevelt Presidential Library in Hyde Park, New York, the Democratic Party National Committee Papers, and the Papers of Franklin Delano Roosevelt as Governor of New York, 1929-32, provided additional information about crippled children's programs before and after the SSA. The Social Welfare History Archives (SWHA) in Minneapolis, Minnesota contains many relevant documents including records of the American Association of Medical Social Workers, the Harriet Bartlett papers, and the SWHA Pamphlet and Newsletter collection. Records about the early crippled children's program in Alabama are held by the Alabama Department of Archives and History (ADAH), Montgomery, Alabama.

Several digital sources of information also supplied primary sources for this research. The *Proceedings of the National Conference on Social Welfare* (1874-1982) are available on-line from The University of Michigan Digital Library Text Collections, Ann Arbor, Michigan.<sup>58</sup> The collection can be searched with appropriate terms or browsed by year, and pages from the *Proceedings* can be downloaded. The website for

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<sup>58</sup> "National Conference on Social Welfare Proceedings (1874-1982)," University of Michigan Digital Library, <http://quod.lib.umich.edu/n/ncosw/>.

the Maternal and Child Health Library at Georgetown University had posted over 450 digitized documents and publications from the USCB, including annual reports from 1912 to the 1930s.<sup>59</sup> The Home Economics Archive: Research, Tradition and History (HEARTH) is a digital collection of journals, books and other publications about home economics, hygiene, child care and other related topics sponsored by Cornell University. Works utilized from this collection included *The Child*, the official journal of the USCB from 1935 to 1950, and several published reports from the 1930 and 1940 White House Conferences on Children.<sup>60</sup> Google Book Search is an online reference tool for searching and locating books. This source helped me to locate many of the primary sources, books and reports, used in this study.<sup>61</sup> Some of these works could be downloaded directly from Google Books such as the New York State Department of Health's *Thirty-Seventh Annual Report of the State Department of Health of New York for the Year* (1917). Other books required the use of Inter Library Loan services at The University of Alabama's Gorgas Library or the University of Alabama at Birmingham's (UAB) Mervyn Sterne Library. Similarly, Google Scholar was used to search for primary source journal articles.<sup>62</sup>

Hand searches of paper copies of several journals also yielded primary source journal articles. Specific publications that I searched by hand included *The Crippled Child* (inclusive years searched 1927 to 1945) at the University of Tennessee, Memphis, in Memphis, Tennessee; *The Survey* (inclusive years searched 1925 to 1945) at the

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<sup>59</sup>Maternal and Child Health Library, Georgetown University, <http://www.mchlibrary.info/history/childrensbureau.html>.

<sup>60</sup> Mann Library, Cornell University, "Home Economics Archive, Research, Tradition and History (HEARTH)," <http://hearth.library.cornell.edu/>.

<sup>61</sup> Google, "Google Books," <http://books.google.com/bkshp?hl=en&tab=wp>.

<sup>62</sup> Google, "Google Scholar," <http://scholar.google.com/schhp?hl=en&tab=ps>.

Birmingham Public Library in Birmingham, Alabama; and the *American Journal of Diseases of Children* (inclusive years searched 1925 to 1945), the *Journal of the American Medical Association* (inclusive years searched 1925 to 1945), and the *American Journal of Public Health* (inclusive years searched 1925 to 1945), all available at the UAB Lister Hill Library in Birmingham, Alabama.

## Methods

Methods used to obtain copies of the original documents included photocopying, printing from microfilm and microfiche, taking digital photos, and downloading digital copies from on-line sources. Once collected, the original documents were evaluated for quality and relevancy to the research questions. Four categories of questions were used to assess each document: 1) witness, 2) time, 3) biases, and 4) relevancy to research questions. The document checklist in Appendix B provided a guide to assess all primary sources. Multiple primary sources were used to reduce inconsistencies and check possible errors in the interpretation of the evidence. Possible errors that could be made in conducting this research included: 1) reading the present into past events, 2) concluding that an event is the result of a single factor, and 3) a failure to understand cultural values and customs.<sup>63</sup> Issues of internal and external validity also become important when assessing primary sources.<sup>64</sup> Specifically, internal validity refers to how consistent the document is with itself, and external validity refers to how consistent the document is with other sources or information from the period.

I used to a method developed by Teri Combs-Orme to review the *Proceedings of the National Conference on Social Work*. Combs-Orme searched the *Proceedings* for

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<sup>63</sup> Leighninger, "Historiography," 355.

<sup>64</sup> Stuart, "Historical Research," 456.

references on infant mortality as a way to understand how the social work profession worked to improve infant and child health in the United States.<sup>20</sup> She searched the index of each *Proceeding* from 1900 to 1979 for terms related to infant mortality. A presentation was included in the study if it referenced the term “infant mortality” or “infant death.” Combs-Orme tallied the number of relevant articles per year. To increase the reliability of her study, she conducted two separate searches, six months apart, and then compared the results from the two searches. Combs-Orme found the yearly totals from the two data sets to be 74% identical, and concluded the method to be reliable. She organized the yearly tallies in a line graph that presented the number of *Proceeding* presentations on infant mortality by decades. She then discussed the role social work played in reduction of infant mortality during the twentieth century.

Following the same methodology, I searched the *Proceedings* from 1874 to 1949, using the search tool available with the on-line *Proceedings* from The University of Michigan Digital Library Text Collections.<sup>65</sup> I used the following search terms: “crippled,” “crippled children,” “deformed,” “physical defects,” and “handicapped.” If a presentation was positive for one of these search terms, I reviewed the article and included it in the yearly tallies if it discussed crippled children. I completed two searches, six months apart (September 2008 and March 2009), and compared the two data sets. Using Excel 2007, I conducted a correlational analysis to compare the yearly tallies of the two data sets ( $r = .85$ ) and found the two data sets to be mostly identical. I also organized my data into a line graph to show the number of presentations by decade, and then discussed the interest of Conference participants based on the number of

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<sup>65</sup> “National Conference on Social Welfare Proceedings (1874-1982),” University of Michigan Digital Library, <http://quod.lib.umich.edu/n/ncosw/>.

presentations for each decade. Additionally, I obtained permission from Dr. Combs-Orme to reproduce her data and created another line graph to compare the presentations for infant mortality and crippled children from 1900 to 1939. The proceedings from the first three *White House Conferences on Children* were reviewed for content related to crippled children and types of participants who presented or participated in the conferences. Search terms used included crippled, crippled children, deformed, physical defects, and handicapped.

To provide 2008 values for expenditures for crippled children, I used an online calculator available from the website, *MeasuringWorth*.<sup>66</sup> The calculator was developed by Lawrence H. Officer, a Professor of Economics at University of Illinois at Chicago, and Samuel Williamson, a Professor of Economics, Emeritus, at the Miami University in Ohio. The calculator was used by inputting the initial year, initial dollar amount and the comparison year which was 2008 for all calculations. Output from the calculator provided six possible indicators of relative value for the US Dollar. The Gross Domestic Product (GDP), the market value of all goods and services produced in a given year, was the indicator used for this study because it provided a measure of “how much money in the comparable year would be the same percent of all output.”<sup>67</sup>

## Conclusion

This study is about the development of services for crippled children in the United States from small reform efforts at state and local levels to a national program supported by the federal government. The study’s research questions focused on how the federal

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<sup>66</sup> Officer and Williamson, “Six Ways to Compute the Relative Value of a U.S. Dollar Amount, 1774 to Present,” <http://www.measuringworth.com/>.

<sup>67</sup> Officer, Lawrence H. and Williamson, Samuel H. "Measures of Worth," MeasuringWorth, 2008 dollars. Available at: <http://www.measuringworth.com/worthmeasures.html>

CCS program was created in 1935, and what influenced the program's growth during its early years. To answer the questions, I reviewed primary and secondary sources at several archives across the country. Using the questions outlined in Appendix B, I evaluated evidence from primary sources documents and interpreted this evidence to answer my research questions. Possible errors that could have been made during the analysis include presentism (using events from the present to interpret the past) and concluding a single-factor or cause contributed to an event or outcome.

## APPENDIX B

### **Document Checklist**

#### **Title of Document:**

#### **Date Reviewed:**

#### **Quality of the witness or creator of the document:**

1. Who was the author?
2. Did the author witness the event? If not witnessed, how was the author involved with the event?
3. What was the author's purpose in recording the document?
4. What were the author's credentials and expertise?

#### **Time frame of the document.**

Did the author record the event immediately or many years later?

1. When was the event recorded?
2. How long after the event did the witness create the document?
3. Does author's memory or self-promotion affect the document?

#### **Biases introduced into the documents by their authors and creators:**

1. What were the author's biases?
  - a. Did the author promote reform or professional efforts?
  - b. Did the author promote federal or state interests?
  - c. Did the author promote public or private efforts?

2. What was the intent of the document? To describe or persuade?
3. Does the document contradict other primary sources?

**Relevance to the research questions:**

1. Does the document speak to the creation of the federal CCS?
2. Does the document discuss the development of the federal CCS?
3. What was the primary purpose of the document?
4. Who was the intended recipient of the document?
5. What degree of involvement did the author(s) have with the events described in the document?

**Notes:**

## APPENDIX C

### TITLE V- GRANTS TO STATES FOR MATERNAL AND CHILD WELFARE

#### PART 2-SERVICES FOR CRIPPLED CHILDREN

##### APPROPRIATION

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

##### ALLOTMENTS TO STATES

SEC. 512. (a) Out of the sums appropriated pursuant to section 511 for each fiscal year the Secretary of Labor shall allot to each State \$20,000, and the remainder to the States according to the need of each State as determined by him after taking into consideration the number of crippled children in such State in need of the services referred to section 511 and the cost of furnishing such service to them (b) The amount of any allotment to a State under subsection (a) for any fiscal year remaining unpaid to such State at the end of such fiscal year shall be available for payment to such State under section 514 until the end of the second succeeding fiscal year. No payment to a State under section 514 shall be made out of its allotment for any fiscal year until its allotment for the preceding fiscal year has been exhausted or has ceased to be available.

##### APPROVAL OF STATE PLANS

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

administering State laws providing for vocational rehabilitation of physically handicapped children. (b) The Chief of the Children s Bureau shall approve any plan which fulfills the conditions specified in subsection (a) and shall thereupon notify the Secretary of Labor and the State agency of his approval.

#### PAYMENT TO STATES

SEC. 514. (a) From the sums appropriated therefor and the allotments available under section 512, the Secretary of the Treasury shall pay to each State which has an approved plan for services for crippled children, for each quarter, beginning the quarter commencing July 1, 1935, an amount which shall be used exclusively for carrying out the State plan, equal to one-half of the total sum expended during such quarter for carrying out such plan. (b) The method of computing and paying such amounts shall be as follows: (1) The Secretary of Labor shall, prior the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), such estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter and if such amount is less than one-half of the total sum of such estimated expenditures the source or sources from which the difference is expected to be derived, and (B) such investigation as he may find necessary. (2) The Secretary of Labor shall then certify the amount so estimated by him to the Secretary of the Treasury, reduced or increased as the case may be, by any sum by which the Secretary of Labor finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State for such quarter, except to the extent that such sum has been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Secretary of Labor for such prior quarter. (3) The Secretary of the Treasury shall thereupon, through the Division of Disbursement of the Treasury Department and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Labor, the amount so certified.

#### OPERATION OF STATE PLANS

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