arately from money payments to recipients, in amounts up to an average of $6 per adult recipient ($3 in Federal funds) and $3 per child recipient ($1.50 in Federal funds). In an effort to obtain the maximum amount possible under the revised formula, some States changed their procedure for paying for one or more types of care. Other States made payments to vendors of medical care for the first time in one or more categories. In 1957–58, all but nine States used vendor payments in one or more programs. About the same proportion of States—roughly 7 out of every 10—made vendor payments under each program; in earlier years far more States had made such payments from general assistance funds than from funds of any one of the other programs.

The increase from 1956–57 to 1957–58 in total per inhabitant expenditures for payments to vendors of medical care probably would have been greater than it was if the Federal provisions for sharing in such payments had not been changed. Some States making vendor payments substantially higher than the new average maximums shifted from vendor payments to money payments for some types of medical care in order to obtain the maximum possible Federal funds. In addition, in 1957–58, the Commissioner of Social Security approved a policy that permitted States to "split" the cost of nursing- and convalescent-home care between a money payment to the recipient for his ordinary living expenses in the home and a payment to the operator of the home for medical needs; formerly, the full cost of such care was in the form of a single vendor payment to the operator of the home.

Among programs, the largest per capita expenditures for vendor payments were from old-age assistance and general assistance funds (table 4). Expenditures from old-age assistance funds amounted to 92 cents, or half the total per inhabitant for all categories combined. Although the per capita expenditure (48 cents) from general assistance funds was much smaller, it accounted for one-fourth of total general assistance payments. In contrast, vendor payments for medical care constituted only about 8 percent of total assistance payments for the four special types of public assistance combined. An unknown, though substantial, amount of vendor payments from general assistance funds, however, was spent on behalf of recipients of the special types of public assistance. At least 11 percent of total vendor payments from general assistance went for medical care for recipients under the special programs.

Table 4.—*Number of States with specified amount of expenditures per inhabitant for vendor payments for medical care, by program, fiscal year 1957–58*

Expenditures per inhabitant for vendor payments for medical care	All programs	OAA	ADC	AB	APTD	GA
Average, all States	$1.84	$0.92	$0.25	$0.03	$0.17	$0.48
Total number of States	53	53	53	53	48	53
No vendor payments	9	17	18	15	15	15
Vendor payments	44	36	35	38	33	38
Less than $0.50	8	10	26	38	30	17
0.50–0.99	7	8	8	0	3	11
1.00–1.49	2	8	1	0	0	3
1.50–1.99	4	3	0	0	0	5
2.00 or more	23	7	0	0	0	2

Under each assistance program, per capita expenditures for vendor payments for medical care were small in relation to total expenditures in most States. Vendor payments amounted to less than 50 cents per inhabitant in three-tenths of the States making such payments under old-age assistance, in three-fourths of the States under aid to dependent children, in almost half the States under general assistance, in all the States under aid to the blind, and almost all the States under aid to the permanently and totally disabled. Vendor payments amounted to as much as $2 or more in seven States under old-age assistance and in 23 States under all programs combined.

Blue Cross Provisions for Aged Persons, Late 1958*

An estimated 6 million persons aged 65 and over—about 40 percent of the population in this age group—have hospitalization insurance. The 79 Blue Cross plans in the continental United States[1] estimate that their enrollment includes about 3.5 million persons who have passed their sixty-fifth birthday. Approximately 400,000 aged persons are enrolled in independent plans. The others—at least 2 million persons—have only insurance company policies. Some persons who are members of Blue Cross or independent plans also have insurance company policies.

Blue Cross plans are thus the major source of prepaid protection against the costs of hospital care among the population aged 65 and over. As the ratio of their aged members to younger members has increased, Blue Cross plans have developed a variety of ways of coping with the problem of the impact of the relatively higher costs on the older segment of their enrollment. Blue Cross membership has been obtained by aged persons in one of four ways, listed in the order of their numerical importance: (1) "left-employ" ("left-group" or "group conversion") contracts, (2) nongroup contracts, (3) group contracts covering aged persons still at work, and (4) group contracts that include retired as well as active employees. Wives are generally included under their husband's contract as dependents, and widows are permitted to continue their membership in Blue Cross plans on a group conversion or nongroup basis after their husband's death.

Most of those in the higher ages who are enrolled in Blue Cross plans originally obtained their membership through their place of work. On retiring they converted their coverage into a "left-employ" contract, which

* Prepared by Agnes W. Brewster and Ruth Bloodgood, Division of Program Research, Office of the Commissioner. Data were developed from plan summaries in the *Blue Cross Guide*, January 1958, and revisions reported by the Blue Cross Association in December 1958.

[1] Data exclude the Puerto Rico Blue Cross plan; Canadian plans have also been omitted.

continued their protection and that of their wives and any young children. Increasingly, however, Blue Cross is writing group contracts that permit the employee to continue his membership after retirement without change in the type of coverage. Since 52 of the Blue Cross plans place no age limits on group enrollment (table 1), some persons have actually first become members of Blue Cross groups, paying group premium rates, after reaching age 65.

Seventy-four Blue Cross plans permit nongroup enrollment, and five do not. Forty-seven of the plans permit nongroup enrollment at any time; eight of these also conduct periodic community enrollment drives in less densely populated areas. The remaining 27 plans periodically open their enrollment for stated periods to persons who are not members of groups. Some of the existing coverage of the aged in Blue Cross plans is derived from a nongroup contract obtained before the age limit on nongroup coverage was enforceable; membership was then continued after age 65 had been reached.

Table 1 shows the upper age limits in effect in the 79 Blue Cross plans, both on a nongroup and on a group basis. Fifty-two plans have no age limits on group enrollment, and 11 of these plans also enroll nongroup members regardless of age. In the remaining plans, the most usual limit is age 65 for both group and nongroup enrollments, although 13 plans have lower age limits for nongroup enrollment and five have higher ones.

In the past 4 years the age limits on nongroup enrollment have been lifted entirely by two plans, lowered by one plan, and raised by three. Some liberalization has also occurred with respect to group enrollment.

Among the 74 plans allowing nongroup enrollment, 61 require that a health certificate be submitted with the enrollment application and 11 do not. There was no information on this point for two plans. The health certificate may cause rejection of the application, or it may form the basis for identifying preexisting conditions for which benefits are not immediately provided.

Forty-seven plans provide coverage for preexisting conditions after waiting periods that vary in length, 19 provide no coverage in such instances, and three cover preexisting conditions immediately. Information was not clear on this point for three of the plans. The benefits under nongroup contracts, although in general fairly similar to those available under "left-employ" contracts, are more limited in a few plans. The main difference is in connection with preexisting conditions, which are not subject to restrictions in "left-employ" contracts.

Tables 2 and 3 list the types of benefits available to "left-employ" members of Blue Cross plans and hence to the majority of their members who are aged 65 or over. As the tables show, the number of basic or "full" benefit days provided by the 79 plans varies from 21 in 13 plans to 365 in one plan.

That the number of basic benefit days does not give the complete story is evident in table 2. Twenty-three plans offer additional days of partial benefits after the member has exhausted his days of full benefits. Plans offering relatively few days of full benefits are likely to provide additional days of partial benefits. The partial benefit may take the form of 50 percent of the full benefit, for a specified number of days; this arrangement is usual when the full benefit relates to semiprivate or ward accommodations. When the basic benefit is in terms of a dollar amount per day the partial benefit is frequently expressed in dollars; even when so expressed, it may also equal 50 percent of the basic benefit.

In addition to the plan providing 365 days of benefits, two other plans afford benefits covering an entire year when the full and the partial benefit days are combined. Four other plans cover stays of more than 6 months in the hospital.

In table 3, the extent to which the basic benefit offsets the cost of the room occupied by the member patient is analyzed. Forty-two plans provide a full "service benefit," when the patient occupies the type of room specified—a semiprivate bed in 30 plans, a ward bed in 12 plans. The remaining 37 plans allow a set dollar amount of credit toward the cost of the room. In some localities and in some hospitals, this allowance equals or exceeds the charge for a semiprivate room. In others it is undoubtedly less than the cost of such accommodations, and an element of coinsurance is thus introduced for each day the patient is hospitalized.

Plans allowing a semiprivate room

Table 1.—*Age limits for group and nongroup enrollment, 79 Blue Cross plans, late 1958*

Upper age limit for nongroup enrollment	Number of plans	Upper age limit for initial group enrollment				
		No age limit	60	65	66	70
Total	79	[1] 52	[2] 1	[3] 24	1	1
No age limit	11	11				
55–56	1			1		
60	11	6	1	4		
64	1	1				
65	45	30		15		
66	3	2			1	
70	2	1				1
No nongroup enrollment	5	1		4		

[1] Includes several plans with an age limit of 65 for initial enrollment of dependents or sponsored dependents.

[2] When 100 percent of a group is initially enrolled, persons aged 60–65 are accepted.

[3] The 65-year age limit applies only to groups of 10 or less in 2 plans (no age limit for larger groups) and in 1 plan does not apply if the employer contributes to the premium.

Table 2.—*Benefit days available under "left-employ" contracts, late 1958*

Number of days of basic benefits [1]	Number of plans	Number of days of additional partial benefits [2]					
		None	30, 35, or 40	60 or 70	80, 90, or 100	180	More than 180
Total	79	56	6	2	9	4	2
21	[3] 13	4	3		3	3	
30, 31, or 35	[4] 23	15	2	1	4	1	
45	1	1					
60	4	2	1	1			
70 or 75	28	25			2		[5] 1
90	3	3					
120	6	5					[6] 1
365	1	1					

[1] Benefit may apply per certificate year or "per period of hospital confinement"; in a few instances may include a deductible amount, such as $25 paid by the patient, or a cooperative payment by the patient of $2.50 per hospital day.

[2] Eleven plans pay 50 percent of the daily room and board charges; 2 pay 25 percent, and 10 pay daily rates of $3, $5, $6, or $10.

[3] Includes 5 plans that increase the number of days of basic benefits for each year of membership up to 3, 4, 5, or 6 years.

[4] Includes 1 plan that increases the number of days of basic benefits from 30 days the first year of membership to 60 days the second year.

[5] Allows 295 days of partial benefits at $10 a day in semiprivate room and at $8 in a ward.

[6] Allows 245 days of partial benefits at $5 a day for persons under age 70 and 20 days at $5 a day for persons aged 70 and over.

Table 3.—*Type of basic benefit available under "left-employ" contracts, late 1958*

Number of days of basic benefits	Number of plans	Type of accommodations		Credit toward cost of room occupied			
		Semi-private [1]	Ward [2]	$5–7 a day	$8–10 a day	More than $10 a day [3]	Ward or semiprivate, limit on room allowance
Total	79	30	12	4	18	12	3
21	[4] 13	8	3		1		[5] 1
30, 31, or 35	[4] 23	10	3	1	4	4	[6] 1
45	1				1		
60	4	1			2	1	
70 or 75	28	9	3	3	7	6	
90	3	1			2		
120	6		3		1	1	1
365	1	1					

[1] "Semiprivate" as defined in the plans may include "2 beds," "3," "4," "2 or 3,", "2-4," "2-6," "2 or more," "other than 1."

[2] As defined, some ward accommodations do not appear to differ from some semiprivate accommodations. Number of beds includes "5 or more," "4 or more," "3 or more," " more than 2."

[3] Credits range from $12 a day (7 plans) to $20 a day (1 plan).

[4] Days of benefit in first year of membership; number increased for additional years of membership.

[5] $11.50 limit.

[6] $14.00 limit.

benefit vary in their practices if the patient occupies a private room. In some plans the patient is credited with the value of the semiprivate room, and in others he is credited with a stated dollar amount. In Washington, D. C., for example, where the charge for semiprivate rooms averages $18.00–$18.50 a day, until recently a patient received a credit of only $10.00 a day toward the cost of a private room, which might cost as much as $23.00 a day. Now he receives a credit equal to the semiprivate room rate.

The rising cost of hospital room and board charges has been reflected in a substantial upward movement among the plans in the dollar amounts of credit toward these charges, as indicated below.

Allowance for room and board	Number of plans	
	1956	Late 1958
$5.00–7.00	12	4
8.00–10.00	19	18
More than 10.00	4	12
Ward or semiprivate room with a limit on room allowance	0	3

By the fall of 1958, five more plans than in 1956 were granting no additional days of partial benefits—an increase more than compensated for by a considerable rise in the number of plans with generous length-of-stay benefits. Thirty-eight plans — compared with 32 in 1956 — allow 60 or more days of basic benefits, and one of the 38 covers 365 days in semiprivate accommodations.

In the period since January 1956, when the Division of Program Research last prepared a detailed analysis of Blue Cross provisions for "left-employ" members, there has apparently been some reduction in the benefits available to older plan members.[2] Only 30 plans in 1958, for example, compared with 38 in 1956, offered a semiprivate room basic benefit; 12 plans in 1958 and seven in 1956 had a ward benefit.

How do the benefits available to "left-employ" members in late 1958 compare with the benefits available under the group contracts held before retirement? In 57 of the 79 plans there is no reduction in benefits under the "left-employ" contracts except when the member had formerly been enrolled in one of the more comprehensive or special group contracts rather than in the standard or most-widely-held group contract. In the remaining 22 plans, some reduction in benefits is made in converting from group to "left-employ" membership. The most frequent type of benefit reduction is in the number of basic days of hospital care. A few plans provide for a lower rate of daily room allowances, others reduce only the basic days of benefit, and still others reduce only the room allowance. In a few plans, the days of additional partial benefits provided to group members are not available under "left-employ" contracts. During 1958 two plans increased the number of basic benefit days for group enrollment, with the same increase applicable to "left-employ" certificates.

The variations in actual benefits among the plans and the changes in benefits that occur in some plans when converting from group to "left-employ" coverage explain the differences in premiums among group, "left-employ," and nongroup members of Blue Cross plans. Table 4 gives the annual premiums under the three types of contracts both for a one-person contract and for a family contract and shows medians and ranges. Table 5 indicates the difference in the annual cost of "left-employ" contracts and group contracts, separately for plans maintaining the same benefit schedule for both types of contract and for plans reducing benefits for those no longer members of a group.

The median premium for a family is $73 under a group contract and $85 under a 'left-employ" contract. The range is wider under "left-employ" contracts—from $51 to $203 a year—than under group contracts — from $44 to $163. On a monthly basis, the additional cost of the "left-employ" contract can be nothing or nearly $10, depending on the plan. If benefits

Table 4.—*Annual 1-person and family premiums, by type of contract, late 1958*

Type of contract	Number of plans	Annual premium	
		Median	Range
Group	79		
One-person		$30.00	$16.20–70.80
Family		73.20	43.80–162.60
"Left-employ"	79		
One-person		42.20	19.20–87.00
Family		84.70	51.00–202.80
Nongroup	74		
One-person		42.00	22.08–87.80
Family		84.00	51.60–202.80

[2] In both the years selected for analysis, every effort was made to select from among the several contracts offered by individual Blue Cross plans those "group," "left-group," and "nongroup" contracts that were most nearly comparable. It is nevertheless possible that variations were inadvertently introduced that make the reductions more apparent than real.

Table 5.—*Additional annual premium cost of "left-employ" contracts, late 1958*

Type of "left-employ" contract	Number of plans	Additional annual premium cost	
		Median	Range
Plans not reducing benefits	57		
One-person	[1] 56	$9.60	$0-55.56
Family	[1] 56	10.44	0-115.92
Plans reducing benefits	22		
One-person	22	7.80	1.20-18.60
Family	[2] 21	7.20	1.80-40.20

[1] Rates not available for 1 plan in which they vary by locality.
[2] Excludes 1 plan where group family rate is higher than "left-employ" family rate; not comparable since "left-employ" members are subject to an 80/20 coinsurance clause and receive lower maternity benefits.

are reduced, the difference between the two types of rates is lower. The greatest difference for a family contract is less than $3.50 a month.

In 1956 the additional annual cost for a family for a "left-employ" contract in more than half the plans ranged from $6 to $15, or from $0.50 to $1.25 a month. In 1958 in half the plans the additional cost to "left-employ" members was less than $1 a month (table 5).

During 1958 no changes were made in premium rates by 50 of the 79 plans. (Most of these plans had raised their rates before 1958.) Among the 29 plans (30 percent of all the plans) that raised rates in 1958, the majority increased the premium on all three types of contracts — group, "left-employ," and nongroup—as the following tabulation shows.

Changes in premiums	*Number of plans*
Total	79
None	50
Increase:	
Group, "left-employ," and nongroup contracts	20
Group and "left-employ" contracts	3
"Left-employ" and nongroup contracts	4
Nongroup contracts	1
Rates for "left-employ" contracts varying by locality	1

UNICEF's New Program for Children*

In a significant first step outside the health field and into the field of child welfare, the Board of the United Nations Children's Fund (UNICEF) at its March meeting approved a plan for aid to children's institutions and day-care centers.

In response to a resolution introduced by the United States Delegation in March 1958, a study was undertaken of the possibility of UNICEF aid in this field. A UNICEF staff member, acting as special consultant to the United Nations Bureau of Social Affairs, visited a number of countries and developed a report[1] that formed the basis for the proposed program. The World Health Organization supplemented this analysis with a special report on the health aspects.[2]

The main report was strongly supported at the Board meeting as being sound both in its general philosophy and in the specific principles that it established. Designed to serve as a basis for planning child welfare projects suitable for submission for UNICEF aid, it should also serve as a valuable resource to countries interested in evaluating existing services to children and planning for their improvement.

The report stresses the importance of training for all levels of workers—a recommendation heartily endorsed by the Board. Services that reach the most vulnerable age groups—infants and young children—are high on the priority list, as are the preventive services, such as day care, which might enable children to live in their own homes. While recognizing that institutional care is not ideal for children deprived of home life, the Board also recognized that in many countries institutions will need to be used for many years to come. Improvement of existing institutions and stimulation of planning for services that strengthen home life are the aims of the program. As the report states, "aid would not be justified unless it were conceived of as a beginning toward a broader and more fundamental objective, namely that of aiding countries develop well-organized national systems of social services which would help preserve and strengthen family life, and foster opportunities for the healthy growth of the personality, abilities, and social habits of the child."

Just as UNICEF relies on the World Health Organization and the Food and Agriculture Organization for technical advice in areas of their competence, so it will receive technical advice on this new program from the Bureau of Social Affairs. Though the sum allotted for the first year is small—$135,000—the development of even a few sound projects will require the full-time services of a competent child welfare worker in the Bureau. UNICEF is authorized to assist in paying such a staff member until the Bureau of Social Affairs can incorporate the position in its budget.

Which countries will wish to have assistance for projects in this field and what the projects will be like is unknown. The program will be watched with interest, however, as the first excursion of UNICEF outside the field of health.

This departure into the field of child welfare is renewed evidence of the dynamic quality of UNICEF's program. Initiated in 1946 to meet emergency needs for food and clothing of children in wartorn countries, UNICEF has changed and continues to change to meet new challenges. By resolution of the United Nations General Assembly in December 1950, UNICEF shed its exclusively temporary character and was directed to use its resources "for the purpose of meeting, through the provision of supplies, training, and advice, emergency and long-range needs of children and their continuing needs, particularly in under-developed countries."

Taking a broad view of the "needs of children," UNICEF has developed in the short space of 8 years an imaginative and flexible program for stimulating and assisting countries to meet those needs. A narrow approach might have limited aid to the traditional field of maternal and child health as conceived in a Western country where other categorical programs provide other segments of service. The planners, however, with a clear awareness of the needs of children around the world, have built

* Prepared by Katherine Bain, M.D., Deputy Chief, Children's Bureau.

[1] UN Economic and Social Council, E/ICEF/377—30 January 1959.
[2] UN Economic and Social Council, E/ICEF/378—18 February 1959.