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SOCIAL WELFARE: 1929 TO THE PRESENT

Price V. Fishback and Melissa A. Thomasson

Probably the most dramatic change in the American economy over the course of the twentieth century has been the growth of social welfare spending by both public and private entities. A key component of that growth has been an expansion in *public* social welfare programs. These programs aid individuals and families in obtaining education and in obtaining insurance against financial hardship in old age and against the risks of workplace disability and unemployment. They also provide financial and other resources for low-income households. The programs sometimes supplement and sometimes replace the provisions of such services by private enterprise or by households. In fact, private spending on these social welfare issues may have been greater than public spending at the turn of the century and is roughly two thirds of the level of public social welfare spending today.

The Social Security Administration (SSA) is the primary source for public social welfare statistics. The SSA defines social welfare spending to include "expenditures on social insurance, income maintenance, health and medical care, education, housing, veterans' benefits, and other welfare services directed specifically toward promoting the economic and social welfare of individuals and families." There is certainly the potential for endless debate over the adequacy of this definition. The SSA chose the definition in part to be compatible with international definitions of social welfare spending used by the Organization for Economic Co-operation and Development (OECD) and the International Labour Office (ILO). Awareness of the potential limitations of the definition and its implied categories has led the SSA to provide the statistics at a low enough level of disaggregation that those with alternative definitions can regroup the data appropriately.

Prior to the 1930s, social welfare spending was primarily the responsibility of state and local governments. As seen in this chapter's essay on public assistance from colonial times to the 1920s and tables contributed by Joan Hannon and Stephen Ziliak on public assistance in the nineteenth century, some local governments provided relief to the poor, but the amounts varied substantially from place to place. Public schools were supported by local taxes, and beginning in the mid-nineteenth century they were maintained by a combination of state and local taxes. In the mid-1850s, states began to establish institutions for the mentally ill and other dependent groups, and state boards of health were in operation in many states by the early 1900s. The federal government largely confined its social welfare responsibilities to aiding veterans of military service, although the pensions for Civil War veterans and their widows and children benefited a substantial segment of society

(see Skocpol 1992; Orloff 1993). During the Progressive era in the early 1900s, reformers pressed state governments for an extensive series of social welfare programs, including workers' compensation laws, unemployment insurance, state-provided health insurance, old-age pensions, and mothers' aid pensions for widowed mothers. Of all these programs, only workers' compensation and the mothers' aid pensions were adopted in a large number of states by 1929. By the mid-1930s a number of states had adopted old-age relief plans, while only Wisconsin had enacted unemployment insurance, and they had not yet started paying benefits by the time the Social Security Act established unemployment insurance as a joint federal–state program.

Prior to the Great Depression, social insurance and many social welfare activities were not considered to be under the purview of the federal government. When the Great Depression led to an unemployment rate of nearly 25 percent in 1933, Franklin Roosevelt and the New Dealers made the argument that the Depression was a national emergency that must be dealt with using federal programs. The New Deal provided emergency assistance to large numbers of unemployed workers and then in 1935 established several long-term social insurance programs with the Social Security Act. Federal actions during the 1930s set precedents for the expansion of the federal government into additional programs that were introduced in later years. After the federal government became involved in the social welfare business, the collection of statistics aggregated to a national level expanded rapidly. Consequently, most of the statistics presented in this chapter are from 1929 to the present. Few national statistics are available for the earlier periods. There was enormous variation across cities, counties, and states in the provision of such services, and we have only shreds of evidence available.

It is important to offer a caveat about use of the statistics on social welfare expenditures. The vast majority of the statistics available on social welfare spending are reported by the SSA in the *Social Security Bulletin* and the *Social Security Bulletin Annual Supplement*. The first lesson to be learned in examining the long time series is that the series are often revised in response to new data, methods, and conceptual definitions. The SSA often publishes the revised versions of the recent data, but in many cases it offers revised information for only those earlier years ending in 0 and 5. In most cases, we try to present the revisions that were available through 1997. Discussions with the people at the SSA who compile the statistics suggest that a search for "the" number in any single year would be futile. The numbers are estimates from surveys, reports of other agencies, and other sources. In a number of settings, the fundamental information is collected only every second, third, fifth, or tenth year, and the observations for the intervening years are interpolations. Thus, the reported observations for each year should be treated as rough approximations of the "true" level. The people at the SSA are careful to try to maintain consistency in the definitions of the series. However, even the revisions are subject to measurement error, and year-to-year fluctuations between a revised statistic for a year ending in 0 or 5 with neighboring years are likely to be subject to measurement error. There is some comfort in our finding that many of the revisions are within 3 percent of the prior reported estimates. This caveat suggests that the data are useful for showing long-term trends over decades but are more sensitive to measurement error in examining year-to-year changes.

A preliminary word on the organization of tables is also in order. Tables Bf188–270 report annual information on social welfare spending under public programs based on the OECD definitions for the period 1929 to the mid-1990s. The tables offer a breakdown of social welfare spending for programs under each of the broad categories of social insurance, public aid, health and medical programs, veterans' programs, education, public housing, and other programs. Many of the programs are funded by several layers of government; therefore, Table Bf196–211 shows the extent to which federal and state or local governments provide the funding for each of the broad categories. Governments are not the only source of social welfare spending. Tables Bf773–892 offer information on social welfare spending by private entities, which account for as much as 13 percent of gross domestic product (GDP) in today's economy. Tables Bf271–772 offer information about specific public programs: the numbers of people affected, the monies spent, and the sources of funding. There are a large number of tables in this area because the development of social welfare programs over the course of the twentieth century has been complicated. The federal, state, and local governments have developed an array of programs to meet different aspects of social welfare. Views have changed about the optimal way to meet these goals. As a result, long-term programs have been redesigned, and even if they have kept the same name, the nature of data collection for the new goals changes the series collected. In other cases, new agencies are developed to take over the duties of the original program. Finally, new programs are added to the list. This has led us in some cases to report multiple overlapping series on the same issues.

Aggregate Trends

The dramatic increase in public social welfare spending in the United States has been one of the major economic trends in the twentieth century. The broadest conceptual measure of public social welfare spending is in series Bf188, which is the series collected by the SSA to be compatible with the OECD/ILO definitions of public social welfare spending. Between 1929 and 1993, social welfare spending in public programs in 1992 dollars (adjusted for inflation by the GDP deflator) has grown at an average annual rate of 6.1 percent per year, nearly double the annual average growth rate of 3.3 percent for real GDP.[1] To give a sense of the size of public social welfare spending, it is useful to compare it to the overall size of the economy by describing the spending as a comparative percentage to GDP. There is one important caveat about this comparison. When social welfare expenditures are compared to GDP in percentage terms, it should not be presumed that this is the contribution of social welfare expenditures to GDP. The GDP is defined as the market value of the output of final goods and services in the economy, while a significant percentage of the social welfare expenditures are transfer payments that would not be considered as additions to the final goods and services measured by the GDP.

[1] The annual average growth rate for social welfare spending between 1929 and 1993 is calculated as $[(S_{1993}/S_{1929})^{(1/(1993-1929))} - 1]*100$, where S_{year} refers to the value for the variable in that year. All other average annual growth rates in the chapter are calculated in the same way using the endpoints of the period examined. The information on nominal GDP, GDP in 1992 dollars, and the GDP deflator used to convert nominal dollars to 1992 dollars is derived from the nominal and real GDP series rounded to billions of dollars that formed the basis for the tables in the Council of Economic Advisors, Economic Report of the President Transmitted to Congress February 1998, pp. 280–2. In Chapter Ca, there is an updated set of GDP numbers.

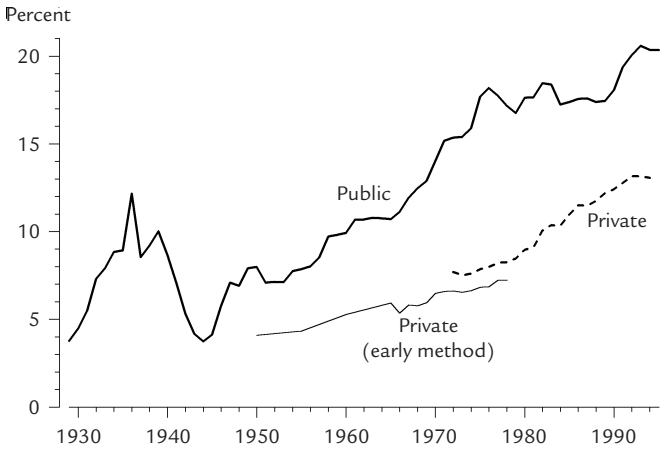

FIGURE Bf-B Public and private social welfare expenditures as a percentage of gross domestic product: 1929–1995

Sources

Series Bf188, Bf773, and Bf781 expressed as a percentage of series Ca1.

Figure Bf-B shows that social welfare spending from public sources rose from roughly 3.8 percent as large as GDP in 1929 to 20.6 percent by 1993. The estimate for 1929 should be considered a very rough estimate because of our lack of accumulated statistics for state and local governments. However, it is likely that the true value is close to this figure. Estimates for 1890 and 1913 prepared for *Historical Statistics of the United States* (1975) suggest that public social welfare spending was approximately 2.4 percent as large as GDP in 1890 and 2.5 percent as large as GDP in 1913.[2] Impressionistic comparisons seem consistent with these estimates. As seen in Chapter Bc, children have spent increasingly longer periods of time in school over their lifetimes. Spending on veterans' programs peaked between 1890 and 1913, as the number of Civil War veterans began to dwindle. Old-age pension programs were typically provided for federal workers in 1920 before they were available to most state and local governments. Finally, public assistance spending by state and local governments was clearly meager relative to the levels we see during and after the 1930s. Social welfare spending spiked above 10 percent as large as GDP during the mid-1930s owing to a combination of low output during the heart of the Great Depression and the large-scale public assistance spending by the Works Progress Administration (WPA) and other New Deal agencies. By the end of World War II, social welfare spending had returned to pre-Depression percentages relative to GDP. We then see its substantial rise over the course of the next fifty years.

The rise in public social welfare spending during the twentieth century was accompanied by a substantial increase in the share of social welfare spending from federal funds (calculated from Table Bf196–211). It is not always obvious how to determine precisely whether the federal government or the state and local governments are the source of the funds. Many programs involved combined activity by the state and local governments and the federal government, and, in a number of cases, the federal government provides grants of funds to be administered by state and local governments in ways that might vary from state to state. The text for Table Bf196–211 describes several situations where the SSA statistics and the national income product accounts (NIPA) have treated the source of the same grants differently. The description that follows is based on the decisions made by the SSA.

Estimates from *Historical Statistics of the United States* (1975) place the federal government's share of social welfare spending in 1890 at 36 percent, primarily as a result of the Civil War Pension program. As the number of Civil War veterans declined, the federal share fell to 20 percent by 1913 (see pp. 332, 341). In 1929, the first year of the SSA's long-term time series, the federal government continued to fund about 20 percent of public social welfare expenditures. The federal share spiked above 60 percent during the New Deal and was at 56 percent during the military mobilization and demobilization of World War II. A long-term secular rise followed through the end of the Carter administration. Since the early 1980s, the share has fallen slowly to below 60 percent, as the federal government has sought to shift more of the responsibility to state and local governments.

The data in Table Bf196–211 show that the federal share of social welfare spending varies greatly across categories. The federal government has always provided nearly all of the funding for veterans' programs and the lion's share of funding for public housing projects and subsidies. In contrast, the federal share of public educational spending has traditionally been below 10 percent because the focus of public educational spending is on elementary and secondary schools, which are primarily the responsibility of state and local governments. After the New Deal fueled a dramatic increase in federal activity, public aid has become largely a shared responsibility between the federal government and the state and local governments. Since 1929, the federal share of public social insurance expenditures has risen markedly from 20 percent in 1929 to over 80 percent in the early 1990s. The rise is largely the result of the rapid expansions in the federal old-age and Medicare programs, which account for roughly 47 and 22 percent of social insurance expenditures, respectively (see series Bf189 and Bf214–215). State and local governments still provide workers' compensation for nonfederal government workers, administer roughly 80 percent of the funds for unemployment insurance, and operate public employee retirement systems that account for 40 percent of the total of federal, state, and local systems.

Social Insurance Programs

The leading contributor to the long-term rise in public social welfare expenditures has been social insurance programs (see series Bf189 and table Bf212–224). As seen in Figure Bf-C, social insurance expenditures have risen from less than 1 percent as large as GDP in 1929 to 10 percent as large as GDP by 1993. The social insurance programs, as defined by the SSA, include the federal Social Security programs for Old-Age, Survivors Insurance (OASI) and Disability Insurance (DI); the Medicare programs for Hospital Insurance (HI) and Supplementary Medical Insurance (SMI); the state programs for workers' compensation insurance; the federal Black Lung Benefits program; temporary disability programs in a handful of states; the federal–state programs for Unemployment Insurance (UI); and retirement and disability programs for federal employees (including the military), state and local employees, and railroad workers. All these programs operate at least to some extent

[2] The estimates are based on Musgrave and Culbertson (1953) and J. Frederic Dewhurst and Associates (1955) and reports of official agencies. See U.S. Bureau of the Census (1975), pp. 330, 340–1.

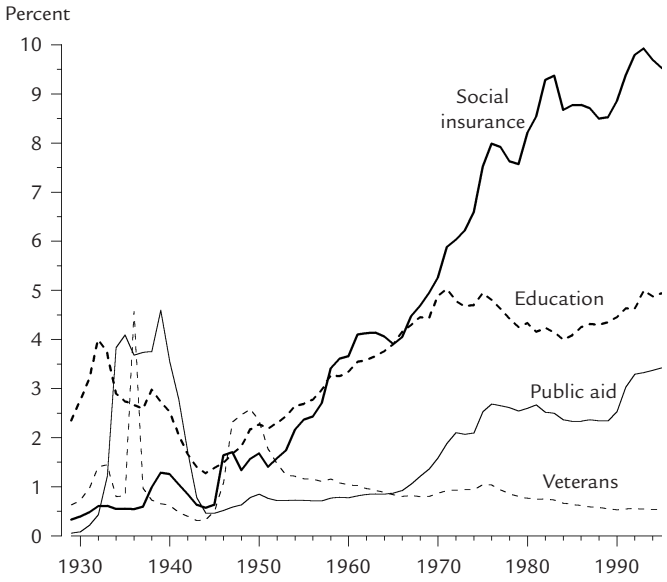

FIGURE Bf-C Public social welfare expenditures as a percentage of gross domestic product, by type of program: 1929–1995

Sources

Series Bf189–190 and Bf192–193 expressed as a percentage of series Ca1.

Documentation

Not shown from Table Bf188–195 are the following lesser categories: health and medical programs (series Bf191), housing (series Bf194), and other social welfare programs (series Bf195). Together they accounted for 0.4 percent of gross domestic product in 1929 and 1.9 percent in 1995.

like insurance. Individuals and/or their employers pay premiums or taxes into a fund. In turn, when the individual reaches old age, is disabled, is unemployed, or is injured on the job, depending on the program, the individual receives payments. In actual operation, it is not always easy to draw the line between the programs defined as social insurance in the SSA statistics and those defined as public assistance. For example, the aged persons receiving Social Security OASI payments in the early 1940s had contributed little, if anything, into the program before they began receiving benefits. Further, many of the early cohorts receiving Social Security received more in benefits than they would have received if they had contributed the amounts to an actuarially sound private pension fund.

Among the industrial nations, the United States was a latecomer in the widespread public provision of social insurance. Germany under Bismarck led the way in the 1880s with sickness, accident, old-age, and disability insurance programs. A number of European countries followed suit. Except for federal provisions for the military, government provision of widespread social insurance did not begin until the majority of states adopted workers' compensation laws in the 1910s and the federal government established unemployment insurance and old-age insurance under the Social Security Act of 1935. Only a handful of states have established temporary disability insurance programs.[3]

[3] The states establishing temporary disability programs are California, Hawai'i, New Jersey, New York, and Rhode Island, as well as the territory of Puerto Rico. There are also government-run railroad temporary disability programs. See Social Security Administration, *SSBASS* (1997), Table 9.C.1.

Old-Age and Disability Insurance

The earliest forms of social insurance by the federal government were limited to disability pension programs for the military (Clark, Craig, and Wilson, 1999, 2003). Before 1855, the military pension systems were primarily disability plans, with the notable exception of officer's pensions from the Revolutionary War. The Continental Congress created the first military pension plan for naval personnel in November 1775 and an army plan a year later. Subsequent revisions to the army plan offered life annuities to officers who remained in the line for the duration of the war. In addition, several colonies offered plans for their militia and naval personnel. All these plans were compromised by the woeful financial state of Revolutionary public finance. Eventually, the Revolutionary pensions were reorganized and ultimately assumed by the federal government after ratification of the Constitution. At that time, the army plan was placed on a "pay-as-you-go" basis, but until its bankruptcy in 1842, the navy plan was funded with monies from the liquidation of prizes. Veterans of subsequent military conflicts, most conspicuously the War of 1812 and the Mexican War, were offered similar plans. Although confusion surrounding antebellum pension records makes an exact accounting problematic, by 1861 roughly 10,500 veterans, widows, or dependents were receiving $1,036,064 in pensions benefits, most of which was for disabilities. In 1855, Congress created the first systematic retirement plan for naval officers. In 1861, that plan was revised, and army officers were included. The Act of 1861, and its subsequent amendments, allowed officers to retire at 75 percent of their active-duty pay after forty years of service. The Civil War, which began in the same year, added substantially to the pension rolls and the pressure on the Treasury to finance those liabilities (Clark, Craig, and Wilson, 1999, 2003). The benefits expanded more widely after the Civil War because of the substantial percentage of the Northern population that participated in the Civil War and later became eligible for Civil War veterans' disability pensions. Definitions of eligibility were broadened enough over time that the Civil War disability program has been considered a precursor of old-age programs for the general public.[4]

Prior to 1920, nonmilitary civil servants received pensions on a case-by-case basis at the discretion of the Congress. The federal government established retirement programs for all federal employees under the 1920 Civil Service Retirement Act (Graebner 1980; Johnson and Libecap 1994; Craig 1995). Since 1987, the

[4] See Skocpol (1992) and Orloff (1993), pp. 134–7. The original law for Civil War pensions in 1862 extended only to soldiers actually injured in combat or to dependents of those killed or disabled. As a result, expenditures on Civil War pensions began declining in the 1870s. The 1879 Arrears Act allowed soldiers who "discovered" Civil War–related disabilities to sign up and receive in one lump sum all the payments they would have been eligible for since the 1860s. In 1890, the Dependent Pension Act severed the tie to combat-related injuries; any veteran serving ninety days in the military was eligible if at some point he became disabled for manual labor. In practice, old age alone became a sufficient disability. A 1906 law declared that the age of 62 and over was a permanent specific disability within the meaning of the pension laws. At the turn of the century, about 15 percent of the elderly in America were receiving Civil War pensions because veterans accounted for about 30 percent of American men over age 65. In the North and Midwest, the proportion receiving pensions was about 40 to 48 percent. Confederate veterans were left out of the system, although some states provided pensions. Georgia was the most generous, with a pension that was less than one seventh as generous as the Northern pension of $360 per year.

federal employee retirement programs have been in transition. Almost all new federal employees hired after 1983 are now under the Federal Employees Retirement System (FERS), which combines Social Security benefits, a basic benefit plan, and opportunities for employees to save in tax-deferred annuities similar to 401(k) plans. Employees hired prior to 1983 are still under the Civil Service Retirement System but have the option to transfer to the FERS.[5]

As of 1929, retirement programs for public employees, including the military (series Bf217), accounted for roughly one third of social insurance expenditures, while state workers' compensation programs (series Bf223) accounted for roughly two thirds. Expenditures for public employee retirement programs have continued to expand at an average annual rate nearly 2.4 times as fast as real GDP, as public employment has expanded and benefit levels have increased (see Tables Bf290–348 and Bf735–745). Even so, the expansion of other social insurance programs has been even more rapid, such that the public employees' share of public social insurance expenditures has declined to 22 percent in the 1990s.

Prior to the 1930s, there were virtually no old-age insurance programs for the general public that resemble the current Social Security old-age pension plan. Between 1915 and 1935, twenty-eight states and two territories passed "old-age pension" plans. These programs appear to be largely relief programs for the aged with low incomes that would allow them to live outside institutions (Stevens 1970, pp. 20–4; Quadagno 1988, pp. 51–75; Costa 1998 pp. 166–7). In compliance with the SSA's categories, we discuss them in more detail in the section on public assistance programs. As the Depression deepened, the federal government became involved in providing public assistance, and there was substantial grassroots public pressure for some type of federal old-age pension plan.[6] The Social Security Act of 1935 established the OASI (the bulk of series Bf214) and UI (the bulk of series Bf218) programs. In 1957 the program was expanded to include DI, and in 1966 the Medicare HI and SMI programs were established for the elderly (series Bf215).

The railroads led the way in establishing private retirement pension programs beginning in 1874. In the 1930s, the federal government established railroad social insurance systems that were separate from the Social Security systems. The railroad system for retirement was established in 1934, 1935, and 1937 (series Bf216 and Table Bf746–761); for unemployment in 1938 (series Bf219 and Table Bf497–510); and for temporary disability benefits in 1946 (series Bf220).[7] Because railroad employment has declined over the past thirty years, expenditures on temporary disability and unemployment insurance in the railroad systems peaked in the early 1960s, while expenditures in the railroad retirement system peaked in the early 1980s.

Even though the first old-age pension checks were not issued until 1940, the Social Security and Railroad Retirement Acts immediately gave retirement coverage to a large segment of the population. Employees with wages and salaries equivalent to roughly 85 percent of total wages and salaries were covered by OASI retirement programs by 1937 (see series Bf272 and Bf274). After dropping during World War II to a low of 72 percent, the figure rose to its long-run level of over 95 percent in the mid-1950s. The self-employed were not covered by the Old-Age, Survivors, Disability, and Health Insurance (OASDHI) system until the 1950 amendments to the Social Security Act. The earnings of the self-employed covered by the OASDHI system (series Bf279) expanded very rapidly during the 1950s, as additional amendments to the Social Security Act expanded the types of self-employment covered under the Act.

Since the introduction of Social Security, there has been a significant rise in life expectancy, a significant population growth during the baby boom, and an increase in labor force participation by women. All these factors have contributed to a substantial increase in the number of workers with earnings that are taxable for contributions to the OASDHI trust funds (series Bf381). Although the number of workers with taxable earnings has increased rapidly over the past six decades, the benefits paid out to Social Security recipients have risen at an even faster pace. After the Social Security Act was amended in 1939 to allow the OASI to become a pay-as-you-go system funded by contributions of taxes by current workers, the size of the tax burden on current workers has risen dramatically over time. Average earnings per worker in covered employment have risen at an average annual rate of roughly 1.6 percent per year from $9,382 in 1937 to $22,618 in 1997 (1992 dollars in both cases). Yet, the rise in benefits paid has been even faster. OASI benefits in 1992 dollars per worker with taxable earnings started at a low of around $10 when the old-age benefits were first paid out in 1940 and have risen to just under $2,000 per worker with taxable earnings in the 1990s.

The rise in the tax burden has been driven by expansions in coverage, increases in average benefits, a rise in the percentage of the population reaching retirement age, and an increase in the longevity of the retirees. Since 1940, the number of families receiving old-age benefits per wage earner reporting taxable incomes in Table Bf-D has increased from below 1 per 100 to nearly 19 per 100 in the early 1990s. The OASI program provides benefits not only to the retired and their dependents but also to the survivors of deceased workers. Following World War II, generally 70 to 80 percent of the benefits in the OASI program have been paid to the retired workers and their dependents with the remainder going to the survivors of deceased workers (see series Bf396–397 and Bf401). As a result, the number of families receiving survivor benefits has risen to about 4 families per 100 wage earners reporting taxable income.

The SSA began paying benefits to disabled workers in 1959 under the DI program, and the number of beneficiary families of disabled workers has risen to a similar level of about 4 families for every 100 wage earners (series Bf416–421).[8] It is anticipated that as the baby boom generation reaches retirement age, the number of families receiving OASI and DI benefits will continue to rise relative to the number of wage earners, putting increasing pressure on the Social Security system.

[5] See the text for Table Bf735–745 for more specific details on the operation of the Civil Service Retirement System and the FERS.

[6] For discussions and other sources on the introduction of Social Security and later amendments to the law, see Graebner (1980), chapter 7; Weaver (1982); Ball (1988); Berkowitz and McQuaid (1992); Costa (1998), Chapter 8; and Schieber and Shoven (1999).

[7] See also Tables Bf290–348 for information on beneficiaries and payments under the railroad systems. The 1934 version of the Railroad Retirement law was declared unconstitutional and replaced by a new act in 1935. For a description of the introduction of the Railroad Retirement law, see Graebner (1980), pp. 153–80.

[8] For a discussion of the introduction of DI, see Berkowitz and McQuaid (1992), pp. 136–41, 186–8; and Weaver (1982), pp. 137–40.

TABLE Bf-D Long-term changes in key indicators for the Old-Age, Survivors Insurance program under Social Security: 1940–1996

	Ratios to the number of workers with taxable earnings					Ratio of benefits to average monthly earnings of workers in covered employment				
						Retired-worker family				
Year	Workers fully insured	Retired-worker families receiving old-age benefits	Survivor families receiving benefits	OASI benefits paid per worker with taxable earnings	Average earnings of workers in covered employment	Male worker only	Female worker only	Survivor family: widowed mother or father and one child	Disabled-worker family: worker, spouse, and one child	Maximum benefit payable to men at retirement
	Ratio	Ratio	Ratio	1992 dollars	1992 dollars	Ratio	Ratio	Ratio	Ratio	Ratio
1940	0.68	0.003	0.001	9	9,382	0.27	0.22	0.40	—	0.49
1950	1.24	0.036	0.010	109	12,439	0.24	0.18	0.41	—	0.24
1960	1.16	0.108	0.027	633	15,712	0.26	0.20	0.43	0.61	0.39
1970	1.16	0.140	0.039	1,015	18,735	0.27	0.21	0.45	0.55	0.40
1980	1.24	0.169	0.041	1,541	19,492	0.38	0.30	0.63	0.74	0.58
1990	1.23	0.183	0.038	1,783	21,621	0.40	0.31	0.60	0.63	0.58
1996	1.22	0.184	0.035	1,913	22,618	0.40	0.31	0.59	0.60	0.60

	Percentage of recipients age 80 and older		Percentage of recipients accepting reduced benefits		Tax rates for employer and employee each			Maximum taxable earnings	OASI trust fund assets
	Male	Female	Male	Female	OASI	DI	HI		
Year	Percent	Percent	Percent	Percent	Percent	Percent	Percent	Million 1992 dollars	dollars
1940	1.8	0.6	—	—	1.00	—	—	27,901	18,889
1950	7.1	3.7	—	—	1.50	—	—	16,408	75,046
1960	12.1	7.2	—	33.4	2.75	0.25	—	20,627	87,336
1970	15.9	14.4	35.9	58.5	3.65	0.55	0.60	25,590	106,475
1980	15.6	18.3	54.8	69.1	4.52	0.56	1.05	42,931	37,831
1990	16.6	22.7	64.6	72.6	5.60	0.60	1.45	54,806	228,834
1996	18.5	25.9	68.0	74.4	5.26	0.94	1.45	56,890	453,165

Sources

GDP deflator used to convert nominal dollars to 1992 dollars: the deflator derived from the nominal and real GDP series rounded to billions of dollars that formed the basis for tables in the Council of Economic Advisors, Economic Report of the President Transmitted to Congress February 1998 (U.S. Government Printing Office, 1998), pp. 280–2.

Workers with taxable earnings: series Bf381.

Workers fully insured for retirement or survivor benefits: series Bf377.

Retired-worker families receiving old-age benefits: sum of series Bf408 and Bf411.

Survivor families receiving benefits: sum of series Bf412–415.

Benefits paid: series Bf395.

Average annual earnings of workers in covered employment: series Bf384 divided by series Bf381. Average monthly earnings of workers in covered employment: average annual earnings divided by 12.

Ratio of benefits to average earnings of workers in covered employment: series Bf462, Bf463, Bf466, Bf472, and Bf474, each expressed as a ratio to the average monthly earnings of workers in covered employment.

Percentage of beneficiaries age 80 and over: series Bf431 and Bf441.

Percentage of beneficiaries accepting reduced benefits: for men, series Bf425 and Bf435.

Tax rates for employer and employee each: series Bf389–391.

Maximum taxable earnings: series Bf386.

OASI trust fund assets: series Bf451.

The increase in the number of families receiving benefits has been driven partly by increases in the life span of the retirees as well as increasing numbers of people accepting reduced benefits for early retirement. The average age of retired-workers beneficiaries has risen by 5 years for males and 6.4 years for females between 1940 and 1996 (series Bf426 and Bf436). Meanwhile the percentage of beneficiaries aged 80 and over in Table Bf-D has risen from below 2 percent in 1940 to over 18.5 percent for males and 25.9 percent for females in 1996. These averages and percentages understate the true rise in life expectancy because women and men became eligible to draw reduced benefits at age 62 in 1956 and 1961, respectively.[9] The monthly benefits are reduced to allow for the increased length of time that the retired worker accepts the benefits.[10] Despite these administrative reductions in benefits, the percentage of male beneficiaries accepting reduced benefits listed

[9] As of 1997, the reduction in OASI benefits for a person who accepted benefits between age 62 and the retirement age of 65 (rising to 67 next decade) was five ninths of 1 percent for each month of entitlement prior to age 65 up to a maximum of 20 percent.

[10] The SSA reports average monthly benefits for those with full benefits and those with reductions for early acceptance. The ratio of average monthly benefits paid to beneficiaries with reduced benefits to average monthly benefits for those with full benefits has remained stable at around 75 percent for both men and women since 1985 (see Table Bf476–483). The ratio gives the impression that people lose more from early retirement than they actually do. Through 1979, the SSA came up with a calculation of what workers who had reductions for early retirement would have received without the reduction (see Table Bf476–483). The ratios of the average reduced benefits to the average benefits they would have received without reduction were roughly 90 percent over the period. Thus, the differences between average benefits for early retirees and regular retirees is caused by differences in the lifetime labor force participation, age at retirement, and possible income differences at the time of retirement of the two groups.

in Table Bf-D has risen from less than 5 percent to 68 percent in 1996, while the percentage for women has risen from 7.5 percent in 1956 to 74.4 percent in 1996.

Another contributor to the rise in spending on Old-Age, Survivors, and Disability Insurance pensions has been a long-term rise in average monthly benefits. Over the past fifty-five years, the average monthly benefits reported in Table Bf461–475 have risen faster than the average monthly earnings for wage and salary earners covered by Social Security (series Bf381 and Bf384). Figure Bf-E shows the ratio of average monthly family benefits to the monthly earnings of wage earners for several different retirement categories. During the 1940s, benefits rose very slowly in nominal terms, and beneficiaries lost ground relative to inflation and average monthly earnings. In the 1950 Social Security Amendments, Congress adjusted benefits upward to accommodate for much of the lost ground during the 1940s. Through periodic adjustments, Congress kept the ratio of benefits to earnings roughly stable through the 1960s. In 1972, Congress established cost of living adjustment (COLA) clauses that allowed benefits to rise with the rate of inflation. During the 1970s, the ratio of benefit levels to monthly earnings rose sharply by roughly 40 to 60 percent. The rapid growth in the 1970s caused Congress to establish new benefit computation rules in 1977 for workers who became newly eligible or died after 1978.[11] Since 1980 male retired workers have received average monthly benefits that are about 40 percent of the average monthly earnings in covered employment (series Bf462). Disabled-worker families have not fared as well (series Bf469–474). In figure Bf-E, the monthly benefits for a disabled worker with a wife and one child started at 60 percent of the average workers' monthly earning when the program was introduced in 1958. They then dropped to around 50 percent by 1969 and then started a sharp climb to 74 percent in the early 1980s. However, by the 1990s disabled-worker benefits had fallen back to around 60 percent. For comparisons of monthly benefits paid to different genders, see Tables Bf-D and Bf476–483.

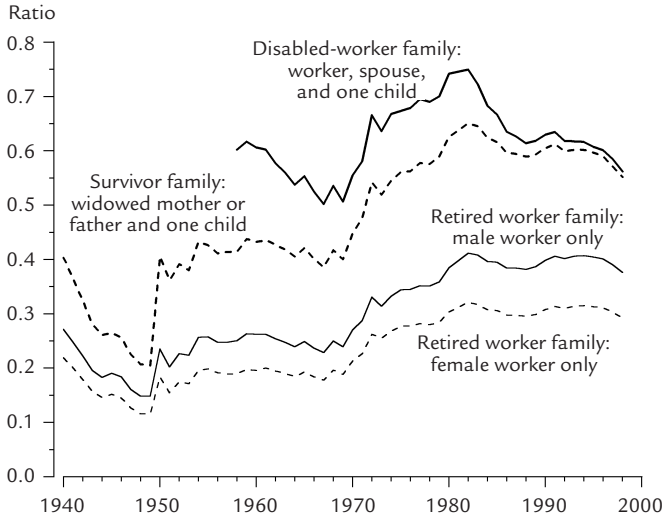

FIGURE Bf-E Old-Age, Survivors, and Disability Insurance – ratio of the family benefit to average earnings of workers in covered employment, by family type: 1940–1998

Sources

Calculated from series Bf381, Bf384, Bf462–463, Bf466, and Bf472.

Documentation

This figure is based on average monthly benefits received by various types of families under the Old-Age, Survivors, and Disability Insurance (OASDI) program. Four family types are displayed: disabled-worker family (worker, spouse, and one child), series Bf472; survivor family (widowed mother or father and one child), series Bf466; retired-worker family (male worker only), series Bf462; and retired-worker family (female worker only), series Bf463. These monthly benefits are displayed here as a ratio of the average monthly earnings for wage and salary earners covered by OASDI, which is computed from series Bf381 and Bf384.

Medicare

Studies in the early 1960s showed that the majority of elderly who had applied for means-tested public assistance to the elderly had been seeking help to pay their medical bills.[12] Congress responded by amending Title II of the Social Security Act in 1965 to establish Medicare, a health insurance program for the aged. The Medicare program consists of two separate but coordinated programs: Part A, Hospital Insurance; and Part B, Supplementary Medical Insurance. Expenditures on the Medicare program since 1966 account for a substantial part of the increase in social insurance expenditures. Starting at zero in 1965, Medicare expenditures accounted for 22.5 percent of all social insurance expenditures in 1993 and were 2.25 percent as large as GDP (see series Bf215).

The HI program is funded by the HI taxes collected from wage and salary earnings (see series Bf391 and Bf394) and therefore is available to all Social Security recipients without payment of any monthly insurance premiums. The HI program tries to use basic insurance methods to limit overuse of hospital services by requiring that the insured pay deductibles and copayments, which are described in Table Bf535–544. Persons who do not qualify for Social Security benefits but who obtain SMI may purchase HI for a monthly premium, which rose from $33 in 1973 to $311 in 1997 (series Bf539).

The Medicare program also offers voluntary SMI coverage for physicians' visits and other medical services (see the text for Table Bf545–557). After individuals reach the proper age or disability status, they can purchase insurance for a monthly premium, which is deducted from the individual's Social Security check (see series Bf542). The government supplements this premium from

[11] Generally, all the retirement and survivor series follow a similar path relative to monthly earnings (series Bf461–468 compared with average monthly earnings for wage and salary earners covered by Social Security, which is calculated as series Bf384 divided by series Bf381 and then divided by 12). The average monthly benefits are influenced by demographic factors and variations in the lifetime labor force activities of the retirees and the survivors. For detailed descriptions about the formulas used to calculate benefits, see Social Security Administration, *SSBASS* (1997), pp. 39–75. The maximum benefits for men in the year they retire give an indication of the potential earnings. The maximum started at about 50 percent of average monthly earnings, dropped during the 1940s, steadied at about 40 percent in the 1950s and 1960s, jumped above 60 percent in the early 1980s, dipped in the late 1980s, and has stayed around 60 percent in the 1990s (see series Bf475 compared with average monthly earnings for wage and salary workers covered by Social Security).

[12] For more discussion of the introduction of Medicare, see Weaver (1982), pp. 151–8.

general revenues (series Bf543–544). The insured pays a deductible of the first $100 for medical care during the year and then a copayment of 20 percent of the cost of treatment (series Bf540–541). The SMI program aspect of Medicare is partially funded by premiums from purchasers of the insurance, with the remainder largely based on general tax revenues because there is no specific tax designated for this program. The premiums paid by participants (series Bf559) covered over 50 percent of the expenditures on medical coverage under the SMI plan (series Bf564) in the early 1970s. Since 1979, premiums have covered less than 30 percent of the costs of the medical coverage provided.

Because health care costs have risen sharply since 1966 – the consumer price index (CPI) for medical care has risen by an average annual rate of 7.3 percent per year – the Medicare program has raised premiums and deductibles at an even faster average annual rate of 10 percent per year for the HI inpatient hospital deductible (series Bf535) and 13 percent per year for the SMI monthly premium (series Bf542). The Medicare program has tried to control costs further by limiting the amounts that hospitals and physicians can receive in payment for treatments.

Funding the Old-Age, Survivors, Disability, and Hospital Insurance Programs

When the OASI system was originally established in 1935, the original intent of the Roosevelt administration appears to have been to establish a pension fund with accumulated reserves, although the initial tax rate established was below the levels needed to make the fund actuarially sound. Congress and the administration abandoned this goal with the Social Security Amendment of 1939 (Meriam 1946, p. 87; Weaver 1982, pp. 111–24; McSteen 1985, p. 39; Quadagno 1988, pp. 119–21; Berkowitz and McQuaid 1992, pp. 123–5, 130–6; Schieber and Shoven 1999, pp. 49–76). Since 1940, the OASDHI program has been a pay-as-you-go system funded by taxes on earnings for wage and salary workers and the self-employed. Workers and employers each pay a separate and matching tax (the self-employed pay the combined rate for workers and employers) to the federal government to fund the system. The rapid long-term rise in beneficiaries relative to the working population and the increase in average benefits relative to average workers' earnings has led to increases in the tax rates to fund the various programs. As seen in Table Bf-D, with only the OASI program to fund, the OASI tax rate was 1 percent for employers and 1 percent for workers on incomes up to $3,000 in the late 1930s and 1940s. The OASI tax rate has risen to 5.35 percent each in 1999 on incomes up to $72,600. The introduction of DI in 1957 tacked on an additional tax of 0.25 percent, which rose to 0.85 percent in 1997. Finally, the introduction of Medicare led to an additional tax of 0.35 percent, which since quadrupled to 1.45 percent in 1997. As of 1999, the total OASDHI tax rate paid by the worker was 7.65 percent, which was matched by the same 7.65 percent rate paid by the employer (see Table Bf377–394).

Not only has the tax rate risen, but the annual earnings subject to the tax rate have risen faster than the average workers' average annual earnings. Total earnings subject to tax have risen close to 90 percent of the earnings of covered workers (series Bf385 divided by series Bf384), while the percentage of workers reaching the maximum has fallen from 36 percent in 1965 to less than 6 percent in the early 1990s. The rise in earnings subject to Medicare taxes followed the same path until the 1990s and then the Omnibus Budget Reconciliation Act of 1993 repealed the maximum. The OASDHI taxes are in many ways more regressive than the income tax. While the income tax does not apply to the lowest income earners, the OASDHI taxes are drawn on the first dollar of earnings. Further, the maximum limits on earnings subject to tax mean that the earners in the top 5 percent of the income distribution do not pay taxes on income beyond the limits. However, it should be noted that the working poor receive some relief from the OASDHI payroll taxes through the earned income tax credit.

The monies from the OASDHI taxes go into trust funds and are to be paid out of these trust funds. The information on assets, receipts, and expenditures for the OASI trust fund appears in Table Bf442–460. The government still maintains a trust fund. Certainly, discussions of the trust fund have dominated the discussions of Social Security in the political arena of the 1990s. It is a pay-as-you-go system with taxpayers paying the OASDHI taxes into the trust fund each year and benefits being paid out each year without a tight actuarial relationship between the two. In fact, the initial recipients of the Social Security benefits received a relatively large subsidy compared to the amounts that they paid into the system. Each succeeding generation that reached retirement has paid in taxes an increasing share of the pension benefits they received. The programs are sound in the sense that should the benefit claims exceed the monies allocated for benefits in the trust fund, the government is able to redirect resources away from other government expenditures to pay the benefits.

Assets in the OASI trust fund slowly built up from 1937 through 1956 in both real and nominal terms because it took time for the benefits paid each year to rise slowly toward 100 percent of receipts collected. The trust fund stayed relatively stable until the early 1980s when increases in tax rates and the arrival of the baby boom bulge in their prime working years caused assets in the fund in 1992 dollars to rise twelve-fold between 1984 and 1996. The process for funding the Medicare HI program is similar (see Table Bf558–567 for details), although assets in the fund declined drastically in 1982 when Congress allowed the OASI trust fund to borrow nearly half the fund to meet a substantial gap between receipts and expenditures. When the loan was repaid in 1985 and 1986, the assets rose sharply and continued to rise through 1992 as a result of an increase in the HI tax (series Bf391). During the 1990s there has been extensive discussion of possible problems with the Medicare trust fund because benefit expenditures have exceeded payroll tax collections. The shortfall in tax collections has the potential to increase in the future because the ratio of taxpayers to those eligible for Medicare is expected to fall, while the elderly population is living longer and health care costs per person are expected to increase.

The assets of the trust fund are largely "invested" in government securities (see series Bf451–452). The government securities are promises by the federal government to repay the principal of the securities plus the stated interest back into the fund sometime in the future. In essence, the federal government has been borrowing money from the trust fund assets each year to fund current government spending on programs other than Social Security. People have begun to worry because the baby boom generation is expected to begin reaching retirement age during the period 2010 to 2030, and the number of recipients per worker is expected to rise sharply. Given a continuation of the status quo, we can anticipate that the

assets in the trust fund eventually will be depleted, as expenditures on benefits exceed OASI tax receipts. Thus, the payment of Social Security benefits will begin to be covered by other tax receipts, leaving less room for funding of other government programs unless there are cuts in OASI benefits or increases in the OASI taxes.[13]

Workers' Compensation

At the turn of the twentieth century, prior to the introduction of state workers' compensation laws, workers could obtain compensation for workplace accidents under the common law if they could show that the employer was negligent. However, such a worker might still be denied compensation if the employer could invoke any of three defenses: The worker had known about and assumed the risk (assumption of risk); the worker's own negligence had contributed to the accident (contributory negligence); or a fellow worker had caused the accident (fellow-servant). A study analyzing several state surveys of families of workers who died in workplace accidents found that between 1900 and 1910 about half of such families received some compensation from the worker's employer, primarily in out-of-court settlements. The average compensation for those families who received a positive amount was about a year's income. When workers' compensation was introduced in the various states in the 1910s, all workers who experienced accidents arising out of or in the course of employment were to receive compensation. The present value of the streams of payments for fatal accidents ranged from roughly two to four times annual income across the states. The average amount of accident compensation received by injured workers and the families of fatalities probably went up between 70 to 200 percent with the introduction of workers' compensation (Fishback and Kantor 2000, Chapters 2 and 3).

During the late 1890s and early 1900s a number of states passed employer liability laws to limit some of the employers' defenses.[14] In the railroad industry, the Federal Employer Liability Act (FELA) of 1908 retained negligence liability but eliminated the fellow-servant defense and weakened the contributory negligence defenses. The assumption-of-risk defense was later eliminated in 1939. Common law rules of negligence without the three defenses continue to govern workplace accident compensation for railroad workers today.[15]

Dissatisfaction with the existing common law system and the results of employer liability laws led employers, workers, and insurance companies to press for the enactment of workers' compensation, which would eliminate the fault basis for compensation. The federal government led the way by establishing a workers' compensation law for federal employees in 1908. As shown in Table Bf-F, between 1911 and 1920 forty-three states enacted workers' compensation laws to require employers to provide compensation for all accidents arising out of and in the course of employment that caused a worker to lose more than a few days of working time. The laws established basic parameters for compensation of injuries. After a waiting period of a few days, workers would receive up to two thirds of their wages during the period of their disability, although the payments were typically capped by a weekly maximum. In turn, employers were required either to purchase insurance from a private or state fund, depending on the state, or to show that they had adequate resources to cover payments to injured workers. Workers' compensation rules vary across states along several dimensions. More detail on the variations in rules through 1929 can be found in Fishback and Kantor (2000), and information for the modern era is available in annual volumes titled *Analysis of Workers' Compensation Laws*, published by the U.S. Chamber of Commerce.

The number of workers covered by workers' compensation rose quickly when the states began adopting a permanent law during that period. When workers' compensation was first introduced, a number of types of employment were exempted, including agricultural workers, domestic servants, many railroad workers in interstate commerce, and, in some states, workers in nonhazardous employments. Further, workers hired by employers with fewer than three to five workers (varying by state) are exempted from the law. By 1940 employees earning wages and salaries accounting for 75 percent of wage and salary disbursements were covered by workers' compensation laws (series Bf283 divided by series Bf273). At the time that Mississippi, the last state to adopt workers' compensation, adopted in 1948, the percentage rose to about 78.1 percent. Since that time, a decline in domestic servitude, railroading, and agricultural employment, as well as expansions of workers' compensation coverage, has led to payroll coverage of about 92 percent.

Since 1929, real expenditures on workers' compensation programs, which continue to be administered by the states, have grown at an average annual rate of 5 percent per year (series Bf223, adjusted for inflation by the GDP deflator). The growth has been caused by expansions in the coverage of injuries and occupational diseases, as well as increases in benefits, even though workplace accident rates have declined since the beginning of the century.[16] Workers' compensation costs as a percentage of covered payroll generally stayed around 1 percent until the late 1960s and early 1970; since then, costs have risen along a strong upward trend to nearly 2.5 percent in 1990 (series Bf520). The rise was driven in part by increased payments for benefits and medical coverage (series Bf521), as well as the introduction of the Black Lung Benefits program for coal miners in 1969.[17] The rise in benefits can

[13] For additional discussions of earlier crises and the potential crisis in financing Social Security and Medicare, see Weaver (1982); Berkowitz and McQuaid (1992); Wolfe (1993); Murphy and Welch (1998); and Schieber and Shoven (1999).

[14] For descriptions of these laws, see Fishback and Kantor (2000), Appendix G.

[15] For a description of the Railroad Compensation system, see Transportation Research Board (1994) and Kim and Fishback (1993).

[16] Although workers' compensation was originally established to insure workers again workplace accidents, the programs in most states were expanded to cover occupation-related diseases. Starting with California in 1915, states began expanding the coverage of workers' compensation laws to include payments to workers' disabled by occupational diseases. By 1939, twenty-three states covered at least some occupational diseases. The states include California (1915), North Dakota (1925), Minnesota (1927), Connecticut (1930), Kentucky (1930), New York (1930), Illinois (1931), Missouri (1931), New Jersey (1931), Ohio (1931), Massachussetts (1932), Nebraska (1935), North Carolina (1935), Wisconsin (1935), West Virginia (1935), Rhode Island (1936), Delaware (1937), Indiana (1937), Michigan (1937), Pennsylvania (1937), Washington (1937), Idaho (1939), and Maryland (1939) (Balkan 1998, p. 64). As of July 1953, every state but Mississippi and Wyoming had at least some coverage for occupation diseases (U.S. Bureau of Labor Statistics 1953, p. 21). By the 1980s, all states had some form of coverage.

[17] The workers' compensation series on costs as a percentage of the covered payroll contains some employer contributions to the Black Lung Benefits program, while the benefits series does not include benefits associated with the Black Lung Benefits program.

TABLE Bf-F The presence of state social welfare programs in the early 1900s

State	Workers' Compensation: year permanently enacted	Mothers' Pensions: year enacted (through 1935)	Old-Age Pensions: year enacted (through 1935)	Aid to the Blind: making cash payments as of August 1, 1935
Alabama	1919	1931	—	No
Alaska	1915	1917	1915	No
Arizona	1913	1917	1933	No
Arkansas	1939	1917	—	Yes
California	1911	1913	1929	Yes
Colorado	1915	1912	1927	Yes
Connecticut	1913	1919	—	Yes
Delaware	1917	1917	1931	No
Florida	1935	1919	—	No
Georgia	1920	—	—	No
Hawai'i	1915	1919	1933	No
Idaho	1917	1913	1931	Yes
Illinois	1911	1911	—	Yes
Indiana	1915	1919	1933	Yes
Iowa	1913	1913	1934	Yes
Kansas	1911	1915	—	Yes
Kentucky	1916	1928	1926	Yes
Louisiana	1914	1920	—	Yes
Maine	1915	1917	1933	Yes
Maryland	1912	1916	1927	Yes
Massachusetts	1911	1913	1930	No
Michigan	1912	1913	1933	No
Minnesota	1913	1913	1929	Yes
Mississippi	1948	1928	—	No
Missouri	1926	1917	—	Yes
Montana	1915	1915	1923	No
Nebraska	1913	1913	1933	Yes
Nevada	1913	1913	1925	Yes
New Hampshire	1911	1913	1931	Yes
New Jersey	1911	1913	1931	Yes
New Mexico	1917	1931	—	No
New York	1913	1915	1930	Yes
North Carolina	1929	1923	—	No
North Dakota	1919	1915	1933	No
Ohio	1911	1913	1933	Yes
Oklahoma	1915	1915	—	Yes
Oregon	1913	1913	1933	Yes
Pennsylvania	1915	1913	1934	Yes
Rhode Island	1912	1923	—	No
South Carolina	1935	—	—	No
South Dakota	1917	1913	—	No
Tennessee	1919	1915	—	No
Texas	1913	1917	—	No
Utah	1917	1913	1929	Yes
Vermont	1915	1917	—	No
Virginia	1918	1918	—	No
Washington	1911	1913	1933	Yes
West Virginia	1913	1915	1931	No
Wisconsin	1911	1913	1925	Yes
Wyoming	1915	1915	1929	Yes

Sources

Workers' compensation laws: Fishback and Kantor (2000), pp. 103–4.

Mothers' Pension laws: for laws enacted prior to 1920, see Thompson (1919), pp. 7–11; and for laws enacted after 1920, see Skocpol (1992), p. 457. See also Moehling (2002).

Old-Age Pensions: Stevens (1970), pp. 20–4; and U.S. Committee on Economic Security (1937), pp. 160–71.

Aid to the Blind: "Public Provision for Pensions for the Blind in 1934," *Monthly Labor Review* 41 (3) (September 1935): 584–601; reprinted in Stevens (1970), pp. 29–31.

Documentation

Workers' compensation laws. The year listed is the date at which a permanent law was enacted. New York passed a compulsory law in 1910 and an elective law in 1910, but the compulsory law was declared unconstitutional, and the elective law saw little use. New York passed a compulsory law in 1913 after passing a constitutional amendment. Kentucky originally enacted a law in 1914, but that law was declared unconstitutional. The permanent law for Kentucky was enacted in 1916. The Missouri General Assembly passed a workers' compensation law in 1919, but it failed to receive enough votes in a referendum in 1920. Another law passed in 1921 was defeated in a referendum in 1922 and an initiative on the ballot was again defeated in 1924. Missouri voters finally approved a workers' compensation law in a 1926 referendum on a 1925 legislative act (see Kantor and Fishback 1994). Maryland (1902) and Montana (1909) passed earlier laws specific to miners that were declared unconstitutional.

Mothers' Pension laws. State provisions in Missouri (1911), California (pre-1913), Wisconsin (1912), Michigan (1911), and Oklahoma (1908) endowed funds similar to Mothers' Pensions in indirect ways. Some of the provisions were limited to specific cities, and others were indirect means of providing funds to dependent children. Arizona in a 1914 referendum passed a Mothers' Pension and Old-Age Pension system that hinged on the abolishment of the almshouses in the state, but it was found unconstitutional

(continued)

TABLE Bf-F The presence of state social welfare programs in the early 1900s *Continued*

(Thompson 1919, pp. 7–9). The 1917 Arizona law was also considered "unworkable," and a new law was enacted in 1921 (Lundberg 1921). More detail on the specifics of Mothers' Pension laws as of 1934 are available in Stevens (1970), pp. 28–9, and U.S. Committee on Economic Security (1937), pp. 233–49. There is some disagreement about whether Alabama had adopted a Mothers' Pension law in 1931; members of the Children's Bureau and later the U.S. Social Security Administration considered the law to be more in the nature of a poor-relief statute than the provision of long-term care for children (Abbott 1934; Bucklin 1939).

Old-Age Pensions. Arizona set up an Old-Age Pension subject to the elimination of almshouses in a referendum in 1915, but the pension was declared unconstitutional. Pennsylvania passed an Old-Age Pension law in 1923, but it was declared unconstitutional in 1924. Nevada also passed an act in 1923 that was replaced by the 1925 act listed in this table.

be explained in part by a series of amendments to state laws in the 1970s that sharply increased the weekly maximums that could be paid for benefits.

During the 1980s and early 1990s, rising medical expenditures have been a prime contributor to rising costs. Expenditures on medical and hospital benefits have risen to 40 percent of workers' compensation expenditures since 1980 after accounting for less than one third of worker's compensation expenditures for the rest of the century (see series Bf224 as a percentage of series Bf223; see also series Bf513 as a percentage of series Bf512). In the early 1990s, employers and insurers have begun managing their health care costs more closely and have limited the growth of medical costs. Similarly, disability benefits as a percentage of covered payroll have risen over time as reforms of workers' compensation expanded the range of workplace injuries and diseases covered (series Bf515 as a percentage of series Bf283). In contrast, the percentage of the payrolls spent on paying the survivors of fatal accidents has stayed relatively constant at below 0.1 percent from the 1940s through 1970 and again from the 1980s to the present. There is one blip in the survivors of fatally injured series that needs some explanation (series Bf516). The percentage of covered payroll paid out to survivors of the fatally injured rose sharply between 1970 and 1973 because the federal Black Lung Benefits program was put into effect. The impact of the Black Lung Benefits program was so dramatic because of the accumulation of a number of years of survivors all being added to the system in the span of three years. As soon as the Black Lung Benefits program stabilized, the survivors' benefits reached a steady state of about 0.1 percent of the payroll and have declined in the 1990s.

The general rise in workers' compensation benefits as a share of the payroll should not necessarily be considered a sign that workplaces have become more dangerous. Workers' compensation has increasingly provided benefits for a wide range of injuries and diseases for which compensation would not have been awarded earlier in the century. The series on the occupational injury and illness rate for all occupations shows that the number of cases of injury and illness per 100 workers in the private sectors has fallen by 32 percent since 1972, while the number of lost workday cases has stayed roughly constant (series Ba4750–4751).

Although the states establish the basic rules for compensation, employers can obtain insurance to cover their compensation responsibilities from private insurance carriers in the majority of states and from government-sponsored insurance funds in roughly half of the states, or employers can self-insure as long as they demonstrate sufficient resources to handle their benefit obligations. Between the end of World War II and 1970, the distribution of benefits paid by these various insurers stayed relatively constant. The percentage of benefits paid by private insurers was roughly 62 percent, by state and federal funds roughly 25 percent, and by self-insurers about 12 to 15 percent (series Bf517–519, each as a percentage of series Bf512). The introduction of the Black Lung Benefits program in 1970 led to a sharp rise in the state and federal insurance funds, as a large number of workers not previously covered received federal coverage for black lung disease. Since 1973, the trend has been to return more of the insurance activity to private insurers, and many employers have increasingly self-insured.

Black lung (pneumoconiosis), which struck large numbers of long-time coal miners, is one of the most notorious occupational diseases. The Federal Coal Mine Health and Safety Act of 1969 established a Black Lung Benefits program to provide monthly benefit payments to coal miners who are totally disabled and to the widows and dependents of coal miners who died as a result of pneumoconiosis. Table Bf525–534 shows the number of persons receiving black-lung benefits under the two administrative systems.[18] The SSA is responsible for the payment and administration of benefits with respect to claims filed through June 30, 1973 (and for certain survivor cases before December 31, 1973). The Black Lung Benefits Act of 1972 transferred to the Department of Labor jurisdiction over all claims after July 1, 1973. The number of recipients of black-lung benefits peaked around 1980 at over 500,000 people. The annual number of beneficiaries has halved since, in part as a result of declines in the number of underground coal miners. Another contributor to the decline has been the deadliness of the disease, which has caused the number of miners and their dependents who receive benefits to fall sharply; meanwhile, the number of widows receiving benefits has fallen at a much slower pace.

Unemployment Insurance

Although a few firms had experimented with unemployment insurance between 1894 and the 1930s, public provision of modern unemployment insurance was not established at any level of government prior to the 1930s (Lescohier 1966, pp. 259–69). A number of state legislatures considered the adoption of unemployment insurance during the late 1910s and 1920s, but only Wisconsin adopted a law in 1932 and began to administer it (Brandeis 1966, pp. 616–24; Berkowitz and McQuaid 1992, pp. 109–15). The Wisconsin system had not yet begun paying benefits when the Social Security Act of 1935 established UI as a federally mandated program run by the states. The states collect payroll taxes from employers to fund the system. Wisconsin,

[18] The miners receive benefits that are 37.5 percent of the monthly pay rate for federal employees in the first step of grade GS-2, adjusted for the number of dependents. If a miner or surviving spouse is receiving workers' compensation, unemployment compensation, or disability insurance payments under state law, the black-lung benefit is offset by the amount being paid under these other programs. The program is funded by a tax paid by employers per ton of coal mined.

based on its early start, was ready to pay benefits as early as 1936, while the remaining states first had to pass enabling legislation and then accumulate reserves for two years before the programs could begin paying out funds to unemployed workers. By 1938, roughly 75 percent of payrolls were covered by unemployment insurance (series Bf280 divided by series Bf273). The percentage rose to a peak of 98 percent in 1979 and fell back to about 92.4 percent in 1994. Covered employment includes employment in industrial and commercial establishments of eight or more for the period 1941–1955 and four or more for 1956–1970.[19]

To fund the system, employers pay taxes on employee earnings up to a specific maximum per employee in each state. Part of the taxes (0.4 percent of taxable wages in 1970) is remitted to the federal government, which in turn provides grants to the states for the cost of administering unemployment insurance and employment services. The payroll contribution rates for individual employers vary to some extent in response to the unemployment experience of workers in the employer's operation.

Unemployed workers begin receiving benefits in most states after a waiting period of one week is served. In the late 1930s the benefits typically replaced 50 percent of weekly earnings up to a weekly maximum benefit level. The weekly maximum has often served to reduce the percentage of average weekly wages paid to roughly 33 to 41 percent between 1940 and 1970, with a rate in 1995 around 35.5 percent (series Bf489). Since 1940, average weekly benefits in 1992 dollars have risen at a relatively slow average annual rate of less than 1 percent per year from $103.3 in 1940 to $173.9 in 1996 (series Bf488 deflated by GDP deflator). The states establish a maximum number of weeks that unemployed workers can receive payments. These durations ranged from 12 to 22.6 weeks in the late 1930s, depending on the state. The maximums have risen such that by 1970 workers could receive benefits for up to 20 to 36 weeks depending on the state. The average actual duration varies with the business cycle from as low as 7.7 weeks during the extraordinarily tight labor markets during World War II to over 14 weeks in 1958 and 1961, and again in 1995 (series Bf490).

As the labor force has expanded, average weekly benefits have risen, as has the maximum duration of benefits. Total benefits paid in 1992 dollars rose from $2 billion in 1941 to more than $20 billion in the 1990s (series Bf493 deflated by the GDP deflator). As a result, expenditures on unemployment insurance and employment service programs rose along a trend to where they comprised 6.2 percent of social insurance expenditures in 1993 (series Bf218). Of course, unemployment claims are cyclical, with total benefits paid peaking during recessions and declining during economic booms. The unemployed receiving insurance as a percentage of the covered employment payroll was as low as 2.0 percent in 1969 and as high as 6 percent in 1975 and 6.6 percent in 1958 (series Bf485 as a percentage of series Bf484).

Public Assistance Programs

The second leading contributor to the rise in public social welfare spending is public assistance programs. As of 1996, the governments of the United States provided benefits to low-income households through a large number of programs: Aid to Families with Dependent Children (AFDC, which has since been replaced by Temporary Assistance to Needy Families), Medicaid, the Women, Infants and Children (WIC) programs, Food Stamps, General Assistance, work relief programs, Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled. In most cases, these programs are means-tested or provide funds to those with disability. Again, it should be noted that the division of social welfare programs into the specific categories of social insurance and public assistance is somewhat arbitrary and based on the statutory programs and the administrative structure of the programs. Users of the statistics might want to regroup programs into alternative categories.

Over the past seventy years, public aid expenditures, as defined by the SSA, rose from 0.1 percent as large as GDP in 1929 to more than 3 percent as large as GDP in the early 1990s (series Bf190). Prior to the 1930s, public assistance was exclusively the responsibility of state and local governments. There was enormous variation across counties and states in the provision of such services.

In the first few decades of the twentieth century, a number of state governments began to legislate forms of public aid that foreshadowed the aid programs for dependent children, the blind, and the elderly established by the Social Security Act of 1935. During the 1910s, a large number of states enacted mothers' pension laws, which provided for public assistance for dependent children in their own homes. The eligibility for such aid varied from state to state, but aid was most often provided for women with preteen children where the support of the husband was absent.[20] Table Bf-F gives an indication of the timing of the enactment of the mothers' pension laws. The U.S. Department of Labor reported that in forty states with mothers' aid laws about 121,000 children were receiving aid at any given time in 1921 and 1922 (U.S. Department of Labor 1932, p. 99). By June 1931, approximately 250,000 children were receiving $35 million in aid in forty-four states and the District of Columbia. Still, the total public assistance expenditures were relatively small, as the SSA estimates that public aid expenditures were roughly 0.1 percent as large as GDP in 1929.[21]

The states were slower to introduce old-age pensions, which provided public funds to low-income elderly living outside of public almshouses and charity institutions. The dates of enactment of the various laws appear in Table Bf-F. The Alaskan territory led the way in 1915. Arizona citizens passed a referendum to establish old-age pensions, but the program was declared unconstitutional in 1916. At the end of 1928, Alaska, Colorado, Kentucky, Maryland, Montana, Nevada, and Wisconsin had laws that gave each county in the state the option to provide pensions. Yet only Montana and Wisconsin appeared to have established operative systems that were paying pensions totaling $222,599 to 1,221 persons. From 1929 forward, the trend in legislation was to make the old-age assistance systems mandatory for counties. By 1932, eighteen

[19] In some of the states, the covered employment also represents employment in smaller establishments and for additional groups of workers, such as state and local employees or seamen. Although the federal law requires only employers to pay taxes, some states require some workers to contribute as well.

[20] Details on the various eligibility rules as of 1919 can be found in Thompson (1919, pp. 11–19). For a snapshot as of 1934, see Stevens (1970), pp. 28–9.

[21] For descriptions of the mothers' pensions laws as of 1934, see Stevens (1970), pp. 28–9, reprinting materials from pp. 301–10 of U.S. Committee on Economic Security, 1937. For a general discussion of the development of mothers' pensions and their impact, see the work of Theda Skocpol (1992) and Carolyn Moehling (2002).

states were paying out pensions totaling $22.5 million to 102,537 persons.[22]

The final group that received cash assistance payments through state programs was the blind. Many states were generally involved in providing some form of educational and vocational training for blind children, workshops for the adult blind, and field work in providing medical assistance and aid in procuring employment. By August 1935, twenty-seven states were providing cash payments to the blind. Estimates by the U.S. Department of Labor showed that in 1934 approximately two thirds of the blind population was receiving some form of cash grants. The average value of monthly grants across the twenty-seven states was nearly $20, but the averages ranged from a low of $0.83 in Arkansas to a high of $33.12 in California.[23]

During the Great Depression, state and local governments increased their expenditures fivefold between 1929 and 1932 in response to the dramatic rise in unemployment. When the unemployment rate reached nearly 25 percent of the labor force in 1933, state and local governments and private charitable organizations claimed to be overwhelmed. During the first hundred days of the Roosevelt administration, a series of New Deal Emergency Assistance programs were established (see Table Bf663–678).[24] The initial program was the Federal Emergency Relief Administration (FERA) which spent nearly $200 million between 1933 and 1935 for direct relief to families and work relief for able-bodied workers (about $2 billion in 1992 dollars). In an attempt to increase federal employment through work relief in the short run, the Civil Works Administration (CWA) spent more than $700 million between November 1933 and March 1934. Meanwhile, the Civilian Conservation Corps spent more than $230 million per year for the rest of the decade as they worked to conserve forests, farmland, and other natural sites while providing work and educational opportunities for young men. Possibly the most famous of the New Deal programs was the Works Progress Administration (WPA), later renamed the Works Projects Administration, which provided work relief for unemployed "employables." The WPA spent between $1 billion and $2 billion per year from 1936 through 1940 building schools, roads, post offices, sidewalks, and a host of other projects. The National Youth Administration and the Farm Security Administration were smaller programs that, respectively, employed students and provided aid to farmers in obtaining their own farms. In sum, well over thirty New Deal programs provided aid of some sort during the 1930s. The sudden influx of federal monies caused public aid expenditures to rise as high as 4.6 percent as large as GDP between 1934 through 1940, a percentage that has not been reached again during the long-term rise in public aid expenditures over the past 60 years (series Bf190).

Activities at the state and local level did not cease in 1933 when the federal government began providing relief through New Deal programs. As can be seen in Table Bf621–633, public assistance provided by state and local governments to the aged, dependent children, and the blind and general assistance rose from $837 million in 1933 to $1,665 million in 1935 (more than 85 percent of the expenditures were for general assistance). The number of cases receiving general assistance was 3.2 million in 1933, 5.4 million in 1934, and 2.9 million in 1935. When the WPA replaced the FERA, the federal government disclaimed responsibility for what it defined as unemployables, low-income people who were not considered capable of working. State and local expenditures on direct relief to the unemployables are included under the heading "general assistance" in the public assistance tables (series Bf625 and Bf638). To help fill the void for some groups and building on the precedents established by earlier state legislation, the Social Security Act of 1935 established three joint state and federal programs for Old-Age Assistance, Aid to the Blind, and Aid to Dependent Children (ADC). In October 1950, Congress amended the Social Security Act to provide aid to the totally and permanently disabled. The Old-Age Assistance, Aid to the Blind, ADC, and Aid to the Disabled programs under the Social Security Act are designed to be joint programs with the federal government providing grants to the states and the states providing additional funds and administering the programs.

A number of the programs have gone through administrative changes. Through legislation enacted in 1972 and effective in 1974, the Supplemental Security Income (SSI) program superseded the Aid to the Blind, Old-Age Assistance, and Aid to the Disabled programs, except in the U.S. territories of Guam, Puerto Rico, and the Virgin Islands.[25] The program for ADC began paying benefits to support payments for a mother or other relative caring for the child in 1950. Under the Public Welfare Amendments of 1962, the program was renamed Aid to Families with Dependent Children to reflect expanded coverage of the adults caring for the dependent children. The AFDC and the Emergency Assistance (EA) programs (series Bf637 and Bf639) have been replaced by the Temporary Assistance for Needy Families (TANF) program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The act was designed to limit the length of time that families could receive assistance and to promote a return to the workforce by those who are able.

The two public aid programs with the fastest growth have been the programs aiding children and the disabled. The number of recipients in the ADC program grew at an average annual rate of 7 percent per year between the end of World War II and the change to AFDC in 1962. The number of recipients then exploded at an average annual rate of 12 percent per year from 1962 through 1971 to reach nearly 10 million. The average monthly number of recipients leveled off at around 11 million before jumping sharply again from 1989 through 1994 to more than 14 million (series Bf630 and Bf644).[26] Annual payments show a generally similar

[22] See Brandeis (1966), pp. 613–6; Stevens (1970), pp. 20–24, based on U.S. Committee on Economic Security (1937), pp. 156–70; Quadagno (1988), pp. 51–75; and Costa (1998), pp. 166–7.

[23] U.S. Department of Labor (1935), pp. 584–601. See also Stevens (1970), pp. 29–31.

[24] The Hoover administration in 1932 established the Reconstruction Finance Corporation, which made some loans to state and local governments to help finance relief expenditures in addition to its loans to banks and industries. The loans do not appear in the tables on emergency relief spending because they were expected to be repaid and, thus, were not considered a net cost to the federal government. The impact of the loans will appear in the estimates of assistance provided by state and local governments.

[25] For more information on the extent of state supplementation under SSI, see Table Bf591–598.

[26] To develop a long-term time series for average monthly benefits, number of recipients, and total spending over the period 1936 to 1973 for AFDC (formerly ADC), General Assistance, Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled, users will be forced to splice together two sets of series reported by the SSA in Tables Bf621–662 The U.S. Social

pattern, although it is somewhat amplified by changes in monthly benefits per recipient, which were around $83 (1992 dollars) in the late 1930s (series Bf624 and Bf637). The average benefits rose above $150 (1992 dollars) through the transition to AFDC and into the 1970s. They stayed in the same range during the 1980s but fell off to around $124 prior to the transition to TANF. This decline in the average benefits per recipient may reflect a decline in the average number of children in the families receiving benefits. Just as the average number of children in families in the overall population has fallen, so it appears has the average number of children in families receiving AFDC. The share of the recipients who are children rose slowly from around 73 percent in 1936 to a peak of around 77 percent circa 1960, just before the transition to AFDC. Since then, the share experienced a secular decline to around 65 to 66 percent in the 1990s (series Bf645 as a share of series Bf644 and series Bf631 as a share of series Bf630).

The SSA began offering federal aid to the permanently and totally disabled in October 1950. The program grew from aiding 69,000 recipients in its first year to 1.2 million recipients in 1973 (series Bf628 and Bf642). Since the SSI program was established in 1974, the number of recipients has more than tripled from 1.6 million in 1974 to more than 5 million in 1995, as the coverage of disabilities has expanded (series Bf614 and Bf642). In contrast, the number of recipients of Aid to the Blind rose from 45,000 in 1936 to a peak more than 100,000 in the early 1960s, fell to 78,000 in 1973, and then rose again to an average annual number of about 84,000 in the 1990s (series Bf613, Bf627, and Bf641). The development of the Social Security old-age pensions and Medicare for retired workers and survivors has reduced the number of Old-Age Assistance recipients since 1950 and kept benefits low (series Bf609, Bf626, and Bf640). The number of Old-Age Assistance recipients rose from 1.1 million in 1936 to 2.7 million in 1950, but it fell back to 1.5 million in 1995.[27] Meanwhile, average monthly benefits in 1992 dollars rose to about $250 in the late 1950s and have generally fallen below that level since 1970.[28]

Average monthly benefits in the Aid to the Blind program (series Bf619, Bf650, and Bf657) and permanently disabled programs (series Bf620, Bf651, and Bf658) have risen somewhat faster than inflation since their beginnings. Average monthly benefits in 1992 dollars in the Aid to the Blind program rose from $250 per month per recipient in 1936 to more than $350 under the SSI program in 1995. Meanwhile, Aid to the Permanently Disabled rose from less than $250 in 1950 to more than $350 in the 1990s (in 1992 dollars). Recipients in both programs experienced spikes in 1974 with the transition to SSI and again in 1978. It should be noted that the average benefits in all three programs are well under the statutory maximums. The difference is determined by the extent of disability and the resources available to the person and his or her family.[29]

The General Assistance programs are state-run programs. The expansion of the federal programs for increasing numbers of categories has appeared to reduce the pressure on the states for general assistance. After the huge numbers receiving relief during the 1930s, the number of recipients of general assistance has generally never been higher than 1.4 million in any year (series Bf632 and Bf646). However, the General Assistance program experienced a rapid growth rate of 6.3 percent per year during the initial stages of the War on Poverty in 1964 to 1970. Average monthly benefits per recipient of General Assistance in 1992 dollars have generally been lower than those of Aid to the Blind and Aid to the Disabled, peaking around $250 in 1977 and falling back to $210 in 1982 (series Bf654 or series Bf661 deflated by GDP deflator). Since that time, information on spending in monthly benefits has not been available.

When the federal government established Medicare in 1965 to provide medical insurance for retired workers, it also developed Medicaid to build on and then take over earlier programs for paying vendors for the provision of medical care to persons with low incomes. Medicaid established a federal–state matching entitlement program that provides medical assistance for certain individuals and families with low incomes and resources. The program is a jointly funded, cooperative venture between the federal and state governments. Each state establishes its own eligibility standards, range of services, rates of payment, and administration.

The federal government first became involved in helping to fund payments to vendors of medical care in October 1950 through a Title I amendment to the Social Security Act. The expenditures were made under the programs for assistance to the elderly, blind, disabled, and families with dependent children, which typically involved federal, state, and local activities. The federal government

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and Rehabilitation Service reported information on AFDC to the SSA through 1975. However, beginning in the *Social Security Bulletin, Annual Statistical Supplement, 1976* (p. 200), data on the public assistance programs were reported from a different source, and the new series reported were considered not comparable. In later years, the SSA has reported a consistent series for 1960 to the present and for the years 1960, 1955, 1950, 1945, 1940, and 1936. Both sources are reported here to allow users to develop their own means of interpolating the annual information for the years prior to 1960. Correlations of the monthly benefit figures between the two sets of series are very high. In Table Bf649–662, the correlations between the two versions of the series for the overlapping years of 1936, 1940, 1945, 1950, 1955, and 1960–1973 are 0.998 for average monthly benefits for Old-Age Assistance, 0.999 for Aid to the Blind, 0.998 for Aid to the Permanently and Totally Disabled, 0.977 for AFDC per family, 0.998 for AFDC per recipient, and 0.999 for General Assistance.

[27] Annual information on the number of recipients, amount of payments, and monthly benefits for Old-Age Assistance, Aid to the Blind, and Aid to the Disabled is provided in Tables Bf599–662. In addition to the problems described in the text, a consistent series for the entire period 1936 to 1996 requires that information on the SSI versions of the programs in Table Bf599–620 for the years after 1974 be combined with the information for the territories of Guam, the Virgin Islands, and Puerto Rico, which have remained under the old programs in Table Bf634–648. This fact helps to explain the precipitous drops in each of these series in Tables Bf634–662.

[28] The monthly benefits comparisons for Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled splice together three series. The three programs were superseded by SSI in 1974 in all states and the District of Columbia, so the series shows the average benefits paid under SSI to this group (the benefits are artificially high in comparison with the earlier years because the low benefits for recipients in Guam, Puerto Rico, and the Virgin Islands are not included). So for the Old-Age Assistance program, we have used series Bf618 from 1974 to 1996, series Bf649 for the period 1936–1959, and series Bf656 for the period 1960–1973.

[29] The average monthly benefits listed in series Bf603 are lower than the maximum benefits available because the benefits are adjusted downward as households have access to increasing resources. The monthly SSI benefit rate for persons who are eligible for the maximum rose from $140 for an individual ($195 for a couple) in 1974 to $484 for an individual ($726 for a couple) in 1997. The SSI also provides an additional increment for an "essential person" in the household rising from $70 in 1974 to $242 in 1997. See Social Security Administration, *SSBASS* (1997), p. 92, for listing of legislative history of maximum benefits.

was not involved in medical assistance under the General Assistance programs, which were financed entirely from state and local funds. Medical assistance for the aged under Title I of the Social Security Act was initiated in October 1960 under the 1960 Social Security amendments (series Bf585). The earlier programs for medical care vendor payments (except for General Assistance) were rolled into the Medicare program in 1970.

From the time the federal government became involved in helping to fund payments to medical vendors in 1951 until Medicaid was legislated in 1965, the medical vendor payments skyrocketed at an average annual growth rate of 18.9 percent per year from $527 million in 1951 to $7.8 billion in 1966 (series Bf582 adjusted by the GDP deflator to express the amounts in 1992 dollars). State and local governments were likely to have already been providing some payments to medical care vendors prior to 1951 because the $47 million dollars in General Assistance spending in 1951 was not financed by any federal spending (series Bf590).

Since 1972, the number of Medicaid recipients has grown at roughly 3 percent per year, while vendor payments in 1992 dollars have risen by 7.6 percent per year. Average payments per recipient in 1992 dollars have risen 4.6 percent per year from $1,070 in 1972 to $3,057 in 1996 (series Bf568 and Bf575, with adjustments by the GDP deflator).

In the late 1960s, Congress established a series of additional programs for persons with low incomes. In 1969, Congress established an Emergency Assistance program, which has been rolled into the TANF program and has been aiding more than 50,000 families per month. The Food Stamp program, which began in the early 1960s, was designed to provide low-income households with a means for obtaining an adequate diet by providing them with coupons redeemable for food and for garden seeds and plants. The percentage of the population participating in the Food Stamp program rose sharply in the 1970s to more than 9 percent, dipped during the late 1980s, and was above 10 percent in the mid-1990s (series Aa110 and Bf689). Meanwhile the average monthly value of bonus coupons in 1992 dollars fell sharply during the 1960s to a trough of less than $23 and rose to nearly $70 in the mid-1990s (series Bf691 deflated by GDP deflator).

Another form of public aid, included in series Bf231, has been the development of work-experience training programs. The Manpower Development and Training Act of 1962 and the Equal Opportunity Act of 1964 "spawned a myriad of categorical programs in almost frantic succession" (Franklin and Ripley 1984, p. 6). In 1973, Congress passed the Comprehensive Employment and Training Act (CETA) in a political compromise that replaced the profusion of earlier programs. Whereas the earlier programs tended to be federally run, CETA provided block grants for more decentralized programs. CETA was replaced in 1983 by the Job Training Partnership Act, which furthered the process of decentralization.

Legislation in 1981 established the Low-Income Home Energy Assistance (LIHEAP) program. Block grants administered by Health and Human Services (HHS) are provided to the states to assist low-income households in meeting home energy expenses (Table Bf708–716). Since 1982, between 5 and 9 percent of American households annually receive such assistance. Average LIHEAP assistance expenditures per household in most programs have been in the $60 to $300 range (1992 dollars). The largest annual average expenditures are in the weatherization program, which typically involves capital expenditures, starting at around $400 in 1982 and rising to more than $1,600 in the mid-1990s (1992 dollars).

Health and Medical Programs

The most controversial area of social welfare spending over the past two decades has been public programs for health and medical care. The SSA offers two sets of series on public expenditures on health and medical programs. The first set includes direct spending on public hospitals, military health care, public medical research, school health programs, and medical facilities (series Bf191 and Bf232–240). Expenditures on medical care through veterans' programs, social insurance programs such as Medicare, and public assistance programs such as Medicaid are not included in these series but are listed under the series on public expenditures on health and medical care under other programs (series Bf241). The reason for the exclusion is that these types of expenditures are already included under other parts of the public social welfare expenditures tables.

Those users who seek to combine all health and medical expenditures into one category, no matter how the funds were administered, will find the series on all public expenditures on health and medical care programs useful. Series Bf242 combines expenditures for health and medical care programs with all of the other spending on health and medicine for workers' compensation, public aid, veterans' programs, and Medicare. These totals for all public expenditures are then separated into the categories of health and medical services, research, and facilities construction.

Direct public expenditures on health and medical care programs outside of expenditures under Medicare, Medicaid, and veterans' programs have grown from about 0.3 percent as large as GDP in 1929 to about 1 percent as large as GDP since the 1970s (series Bf191). In general, the federal share of these direct health and medical expenditures has risen from roughly 12 percent in the 1930s to more than 40 percent in the 1990s (see series Bf199 and Bf207). The federal share sharply spiked to 77 percent when federal spending on military health care caused public health care expenditures to exceed 1 percent of GDP in 1943 to 1945.

Although the data in the tables begin in 1929, there was a history of public spending on health and medical care in earlier years. As just one example of a combined federal and state program, consider the spending by the U.S. Children's Bureau authorized by the Shephard–Towner Maternity and Infancy Act of 1921. The Act appropriated about $7 million in federal money for grants in aid to states for the promotion of maternal and infant health and welfare and was distributed between 1922 and 1929. According to the Children's Bureau, this legislation led to expansion of the Birth Registration and Death Registration Areas, establishment of state child-hygiene bureaus and divisions, establishment of permanent state health centers for mothers and children, and, perhaps most important, an accompanying increase in state appropriations for infant and maternal health (U.S. Children's Bureau 1930, pp. 1–3; see also Berkowitz and McQuaid 1992, pp. 73–7). In the SSA listings, the Shephard–Towner spending would appear under series Bf236. The lack of values in the early 1930s in this SSA series may reflect an inability to effectively determine state and local spending on this issue.

Expenditures on health and medical care under other administrative structures include medical expenditures under workers' compensation, under Medicare, and under Medicaid and other public assistance payments to vendors (series Bf241). The expenditures fluctuated between $1 billion and $2 billion (1992 dollars) until the introduction of Medicare in 1966. Rising health care costs

have contributed to an explosion in these expenditures since that time, as they grew to more than $10 billion by 1979 and doubled to more than $20 billion by 1989 (1992 dollars).

During the post–World War II era, the United States has probably been the world leader in medical research, partially as a result of public financing. Public expenditures on medical research were under $30 million until 1947 when in one year they jumped to 149.7 million (series Bf237, converted to 1992 dollars). They first reached $1 billion in 1957 and then experienced another rapid rise to more than $5 billion by 1966. They held steady between $5.5 billion and $6 billion into the mid-1970s and have risen steadily since to more than $13 billion today. On the other hand, public spending on medical facilities construction peaked between $3 billion and $4 billion in the late 1970s and has tailed off since (series Bf240, converted to 1992 dollars).

Education Programs

Public expenditures on education have also outstripped GDP since 1929, growing in real terms at an average annual rate of about 4.5 percent per year. As Claudia Goldin notes in the essay on education in Chapter Bc, one of the keys to growth in the American standard of living has been our educational system. Since World War II, educational expenditures have risen from 1.7 percent as large as GDP in 1947 to roughly 5 percent as large as GDP in 1993. The fastest growth in educational expenditures, as defined by the OECD, occurred in the 1960s and 1970s, when average annual rates of growth in real expenditures neared 8 percent per year. Over the course of the twentieth century, the mix of spending has gone through several changes. As a larger share of the population in each new generation has extended their schooling beyond high school, the shares of public spending on higher education have increased from less than 10 percent to just over 20 percent of public educational spending (series Bf258). Following a sharp rise immediately after World War II, the higher education share peaked in 1984 at around 24 percent and has since declined to just above 20 percent as renewed emphasis was placed on elementary and secondary education. Public spending on vocational and adult education received a boost during the New Deal and then expanded rapidly to a peak of 7 percent of educational spending during World War II (series Bf260). Interest in vocational and adult education was renewed in the 1960s, but spending was virtually eliminated in the mid-1980s. One caveat about the vocational and adult education series: they do not include job training programs such as CETA.

Veterans' Programs

The U.S. government has always provided social insurance, hospitals, and medical care for its veterans (see Clark, Craig, and Wilson 2000). As discussed earlier, pensions for Civil War veterans set precedents for establishing old-age pensions for the general public. Public spending for veterans since 1929 typically has been less than 1 percent of GDP except during periods immediately following major wars (series Bf192). The most unusual increase in the series came when Congress voted to pay a "veterans' bonus" of $2 billion dollars ($20 billion 1992 dollars) in 1936 over Franklin Roosevelt's veto. The bonus provided for the immediate payment to veterans of World War I of their adjusted compensation certificates, which were supposed to come due in 1945. The bonus caused a one-time jump in the veterans' "welfare and other" series and caused the overall veterans' series to rise to 4.6 percent as large as GDP in 1936 (series Bf192 and Bf254).

Between 1929 and the end of World War II, except for 1936, two thirds of the veterans' spending was for pensions (series Bf247). The disability pension program, which is described in more detail in Table Bf762–772, accounts for roughly 50 to 60 percent of veterans' spending, except for the immediate aftermath of World War II.[30] Immediately following World War II, the GI bill, designed to provide educational opportunities for returning veterans, caused veterans' educational spending to rise to around 40 percent of veterans' spending for 1947–1950 (series Bf252). The educational spending tailed off to less than 10 percent by 1960 and remained below 10 percent until the early 1970s, when the aftermath of the Vietnam War led to more educational programs for returning veterans. As in other areas, health and medical spending for veterans has become increasingly important. Health and medical spending accounted for less than 10 percent of veterans' spending prior to World War II. Since World War II, health and medical spending has consistently outpaced all other forms of spending, rising to 42 percent of veterans' spending by 1993.[31]

Public Housing Programs

Public expenditures on housing consist of payments for public housing and housing subsidies for low- and moderate-income families. Federal public housing expenditures got their start under the Housing Division of the Public Works Administration (PWA) during the New Deal with a strong burst of building activity in late 1935 and 1936. The PWA projects were then taken over by the U.S. Housing Authority in 1937, which began a new public housing building program, spending about $40 million per year during the late 1930s (1992 dollars). The spending jumped to close to $100 million per year during World War II and then jumped more than $1 billion in 1946 and 1947 (1992 dollars). Spending fell back to $43 million in 1949 and then rose continuously to about $1.8 billion in 1969 (1992 dollars). Since legislation in 1965, the U.S. Department of Housing and Urban Development (HUD) has overseen the housing programs.[32] After the Housing and Urban

[30] Included among the array of veterans' benefits are two major cash programs: the Service-Connected Disability Compensation program and the Nonservice-Connected Disability and Pension program. The service-connected program pays monthly benefits to honorably discharged veterans who are disabled as a result of injury or disease incurred while in or aggravated by active military duty. In addition, the surviving spouse, dependent children, and certain parents of veterans who die as the result of an injury or disease incurred while in or aggravated by active military duty are also eligible for compensation under the Dependency and Indemnity Compensation (DIC) program. Both disability compensation and DIC benefits are not means-tested. The second cash program provides for means-tested monthly benefits for honorably discharged wartime veterans with limited income and resources who are permanently and totally disabled as a result of a condition not related to their military service. The amount of benefit varies with the number of the veteran's dependents and the severity of the veteran's condition. Pensions for nonservice-connected death are based on need and are paid to surviving spouses and dependent children of deceased wartime veterans.

[31] Additional discussion of the veterans' programs can be found in Chapter Ed.

[32] HUD oversees a wide variety of programs not included in these expenditures, including the Federal Housing Administration (FHA), which insures loans for mortgages and home rehabilitation, and the General National Mortgage Association (Ginnie Mae).

Development Act of 1970 established a national growth policy, public housing expenditures skyrocketed in the 1970s, rising more than 18 percent per year to a level of $11.4 billion in 1980 (1992 dollars). The growth rate slowed to 7 percent per year in the 1980s. Since 1989, the annual expenditures have been around $20 billion (1992 dollars). Government expenditures on housing were focused on public housing provision until the beginning of the 1950s, when state governments began providing subsidies for housing for low- and moderate-income families that accounted for 39 percent of the public housing expenditures. The focus of spending soon returned to public housing through the rest of the 1950s, and then shifted back toward subsidies at the federal, state, and local levels through the mid-1970s, when resources devoted to public housing began increasing again (see series Bf194, Bf202, Bf210, and Bf262).

Other Public Social Welfare Programs

The catchall category in Table Bf263–270 includes spending on vocational rehabilitation, child nutrition, child welfare spending, ACTION, and Office of Economic Opportunity (OEO) programs. Expenditures in these areas have risen about 5 percent per year in real terms since 1929, with the most rapid growth occurring during the 1960s during the War on Poverty. Most of the increase in this miscellaneous category is on programs for child nutrition, including surplus foods under the National School Lunch and Child Nutrition Act. The special OEO and ACTION programs got their start in the mid-1960s. In 1971–1972 the VISTA, foster grandparents, and other volunteer programs were consolidated under the ACTION rubric. Expenditures rose through 1973 and had a significant one-year increase to $3.8 billion at the end of the Carter administration; successive administrations have reduced the spending well below $1 billion per year (1992 dollars).

Private Social Welfare

The impressive growth of public social welfare expenditures and programs sometimes causes us to forget that private entities play an important role in providing assistance to low-income households, insurance, health care spending, and education. Consequently, the growth in public spending has been complemented by similarly rapid growth in private spending on social welfare services. The SSA has developed two sets of estimates of private social welfare expenditures for the periods 1950–1978 and 1972 to the present. Neither of the series is a precise private counterpart of the SSA's public social welfare expenditure series. As seen in Figure Bf-B, private social welfare expenditures have risen from less than 5 percent as large as GDP in 1950 to 13 percent as large as GDP in the 1990s. We do not have good aggregate estimates for private social welfare spending for earlier periods.

Prior to the introduction of the public social welfare programs of the twentieth century, households followed a number of strategies for protecting themselves against misfortune. In the early 1900s, compared with today, households faced greater risk of workplace injury, similar risk of unemployment, and greater risk of disability and illness. With only limited access to public social insurance and relief at the local level, individuals and families developed a number of strategies for dealing with these problems. Many of these methods cannot be easily measured and turned into aggregate national statistics. To deal with the problems of old age, the elderly often lived with their children and their families or in close proximity to relatives. To deal with unemployment, illness, injury, or death, a number of families sent wives and children into the work force.[33] To varying degrees, employers and unions also provided some aid for families of workers injured on the job or fallen ill (Berkowitz and McQuaid 1992, pp. 11–34, 50–67; Jacoby 1997, pp. 10–34).

Both in past and present labor markets, varying combinations of competition for labor among employers and collective bargaining have forced employers to pay higher wages for jobs with greater risks of injury or unemployment. Estimates of the implicit value of life implied by the higher wages have risen over time to a range of approximately $1 million to $10 million in modern labor markets (Moore and Viscusi 1990; Fishback 1998). The higher wages probably did not fully compensate workers for their expected losses, but households used the higher wages to purchase limited amounts of life and accident insurance and to obtain some protection against accidents and sickness by joining mutual societies through employers or fraternal organizations. A number of households accumulated precautionary savings, but these were often not large enough to protect against the loss of the household head's income for more than a few months. Others used pawn shops and other informal sources of credit to tide them over (Haines 1985; Rotella and Alter 1993). People with low incomes without these resources sometimes obtained limited support from local governments, charities, or community groups.

The introduction of public social welfare programs may have partially replaced many of these private mechanisms for dealing with the risks and vicissitudes of life. Social Security pensions appear to have freed the elderly to maintain separate households. Increases in benefits for workers' compensation and unemployment insurance have been shown in a number of studies to be associated with reductions in the wages paid by employers (Moore and Viscusi 1990; Fishback 1998). A number of economists have found evidence that Social Security and other social insurance programs reduce precautionary savings and insurance purchases by households (Feldstein 1974, 1982; Leimer and Lesnoy 1982; Fishback and Kantor 2000). Even charitable donations and organizational activities have been found to be crowded out by public programs in some studies (Abrams and Schmitz 1984; Ziliak 1996, 1997). On the other hand, many of these changes have been marginal responses that apparently have been swamped by other factors because private social welfare spending over the past fifty years has followed an upward trend similar to the one displayed by public social welfare spending (see Figure Bf-B).

The most rapid growth in private social welfare spending since 1972 has come in expansions in the category for income maintenance spending, which is essentially expenditures for employee benefit plans for retirement pensions, life and disability insurance, and supplemental unemployment insurance (series Bf790–795). Since 1972, expenditures on these plans have risen at an average annual rate of 6.3 percent per year after adjusting for inflation. The largest expansion within employee benefit plans has been in private pension plans, which have risen more than

[33] For descriptions of various family strategies, see Modell (1979); Graebner (1980); Goldin (1981); Haines (1985); Keyssar (1986); Rotella and Alter (1993), Haber and Gratton (1994), and Costa (1998).

fivefold in real terms between 1972 and 1994, in part as a result of the expansion of pension options available to employers (Kerns 1995). This rise in private pensions continues a longer trend from the beginning of the twentieth century. The railroad industry was the leader in providing pension plans in the late nineteenth century, and a few other large firms followed suit (Latimer 1932). In 1920, approximately 3 million workers were covered by pension plans (Craig 1995, p. 309; see also Ransom, Sutch, and Williamson 1993). By 1950 approximately 10 million private employees were covered by employer pension plans, and the number had tripled by 1970 (see Table Bf836–853). Similar stories can be told for life insurance, disability insurance, and health insurance benefits, although the growth rates in disability insurance and life insurance expenditures over the past twenty years have not matched the growth in pension spending (Tables Bf786–835 and Bf854–874).

Expenditures of private funds on welfare services by private social service agencies, such as family service agencies, adoption services, group foster homes, the YMCA, the Boy Scouts, and a wide range of other programs, have risen nearly as fast as spending on income maintenance – 6 percent per year in real terms since 1972 (series Bf777).[34]

Even the slowest-growing category of private social welfare spending – education – has grown at an average annual rate of 3.6 percent per year in real terms between 1972 and 1994. This growth is slightly faster than the growth in public spending on education. About 50 percent of the private spending throughout the period has been on current operations in higher education, while about 13 to 15 percent is devoted to current operations in vocational education (see Kerns 1995, p. 69).

An important component of private social welfare spending is expenditures on health care. The U.S. health care system contrasts with the public health care systems of many other countries in that our system is financed by a mixture of direct private spending, spending under health insurance (often provided as benefits by employers), and public programs. Private health expenditures in 1992 dollars have grown at a pace of approximately 5 percent per year since 1960 (series Bf876 deflated by the GDP deflator).[35] Despite this rapid growth, the expansion of Medicare and Medicaid has caused the privately financed share of health care expenditures to fall from 75 percent in 1960 to 54 percent in the 1990s (series Bf876 as a percentage of series Bf875).

One of the major changes in the financing of health care expenditures has been the rise in the role of private health insurance. While payments from health insurers financed only 29 percent of private health expenditures in 1960, by the 1990s health insurance paid for roughly 60 percent of all private health expenditures (series Bf879 as a percentage of series Bf876). This figure might understate the involvement of insurers in medical transactions because the leading alternative category – series Bf878, out-of-pocket medical expenditures by consumers – includes the consumer payments of copayments and deductibles required by health insurers. The rise in the extent of private health insurance coverage of the population has been even more dramatic. Since 1940, the number of people with private health insurance has risen sharply from 12 million to more than 180 million in the 1990s (series Bf887). The rise has been dramatic, but the absence of universal coverage of the population has been a leading public policy issue during the 1990s and early twenty-first century.

The current system of health insurance coverage evolved from "sickness" insurance, which was the primary form of health insurance sold in the early part of the twentieth century through the 1930s. Sickness insurance was designed to replace lost income from illness rather than to pay medical bills. Sickness insurance is still sold today, but the majority of the private protections against lost income from sickness are found in employer programs (Tables Bf854–874).

As medical care became more effective and expensive, Blue Cross (and later Blue Shield) was an early leader in developing health insurance that paid for the direct costs of obtaining medical care. The "Blues" provided coverage to roughly half of the people with insurance in 1940 (series Bf891 as a percentage of series Bf887). A substantial part of the rise in health insurance coverage of medical costs has come from group insurance plans through the person's employer. Tables Bf802–835 show the dramatic rise in health insurance coverage for employees between 1950 and 1976, the point at which these series were no longer collected. The rise was driven in part by federal tax policies during World War II, which were later clarified and encoded by the Internal Revenue Code of 1954, which freed employers from paying taxes on the value of health insurance provided to their workers (Thomasson 1998). The most recent trend in the health insurance industry has been the rise in the number of people covered by health maintenance organizations (HMOs) and other managed care plans. Over the past twenty years the percentage of persons insured by HMOs, managed care plans, and miscellaneous insurance has risen from 10 percent to nearly two thirds (series Bf892 as a percentage of series Bf887).

Summary

"Expansion" is the single best word to use in describing social welfare expenditures during the twentieth century in America. Expenditures have risen at a much faster rate than GDP as the coverage of programs has expanded and the average payments to beneficiaries have increased. Public programs have proliferated, and private social welfare spending has also risen at a rapid pace. Social welfare spending from both public and private sources has grown from less than 10 percent as large as GDP to more than 30 percent as large as GDP over the past ninety years. The result has been a dramatic change in the institutional landscape with regard to social insurance and public assistance. Responsibility for many forms of social welfare activity has shifted from the individual and private organizations to state and local governments to the federal government, although the federal programs are often administered and funded in conjunction with state and local governments. Some public programs, such as Social Security, have expanded in ways that have led to significant public discussion of the possibility of future breakdowns in the government's ability to maintain the promises made to the workers who are currently funding them. Similar problems have arisen in our complex public–private system of health care. The discussions have led to new proposals of innovative ways of dealing with these issues, which in turn may well lead to more complex arrangements in the future.

[34] More extensive information on private philanthropy is available in Chapter Bg.

[35] The SSA obtained its estimates for private spending on health care (series Bf774) from the Health Care Financing Administration, which has reported a longer time series for 1960–1997 in series Bf876.

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