Introduction

In 1926, Harry L. Hopkins, then Director of the New York Tuberculosis Society, who would go on to be one of Franklin Delano Roosevelt’s closest advisers and an architect of the New Deal, wrote: “… the fields of social work and public health are inseparable, and no artificial boundaries can separate them. Social work is interwoven in the whole fabric of the public health movement, and has directly influenced it at every point” (Hopkins 1926). Ninety years later, the American Journal of Public Health republished a 1966 article by Dr. John Stoeckle, illustrating the public health value of social work in a medical clinic (Waitzkin 2016). As noted in a letter of response, social workers have been deeply involved in addressing social determinants of health for more than a century (Zerden et al. 2016). And, although many writings attest to the history of social work in public health, its significance is sometimes overlooked. A review of social work’s past and current efforts can highlight its contemporary value in public health.

Social work in the U.S. is a large, diverse profession of 600,000 practitioners, approximately half of whom are employed in health (Ruth, Sisco, and Marshall 2016). Guided by values of social justice and dedicated to improving well-being, social workers utilize ecological, clinical, and biopsychosocial approaches to work at multiple levels of society, from individuals and families, to neighborhoods, organizations, and government.

Under the umbrella of health social work, there are numerous sub-disciplines, including public health social work, behavioral health, oncology, nephrology, and palliative care social work. The bulk of health social workers serve in direct care roles, such as counseling, health education, and crisis intervention. However, social workers also practice at intermediary levels as navigators and care managers, and at the macro level, in health administration, research, advocacy, and policy (Browne 2012).
A note on terminology: Currently, no one term exists to describe health-related social work. Where indicated, the authors used the terms of the era to describe social work practice. To promote clarity, the term *health social work* is used to describe contemporary practice within health, and *public health social work* to distinguish the sub-discipline that integrates public health into social work.

**The Progressive Era**

Both social work and public health evolved into their contemporary forms during the early 20th century. Reflecting their Progressive Era origins, they shared a historic commitment to health, social welfare, and social justice; from their earliest days, they collaborated on issues such as infectious disease control and maternal and child health (Ruth, Sisco, and Marshall 2016). Social work drew its inspiration from two primary sources: first, the community-oriented settlement house movement, made famous by activists such as Jane Addams, who utilized place-based interventions to address poverty, overcrowding, immigration, and child labor; and, second, the charity organization movement, which used casework to help individuals overcome poverty and avoid dependence on society for aid.

The nascent profession struggled to identify a unified approach to encompass these seemingly incongruent goals, ultimately settling on two major methods that have co-existed, often uneasily, under the banner of social work. Dubbed the “dual heartbeat,” these evolved into casework or “clinical” social work and community or “macro” social work. Casework addressed the social, and later, psychological, needs of individuals and families, while community or “macro” social workers engaged in “cause-based” or structural reforms intended to improve community well-being (Gibelman 2000).
Social work’s early efforts in health utilized both approaches. Social workers carefully demarcated their scope of practice by limiting focus to the “social side of illness,” leaving disease and disease control to medicine and public health. Hospitals, and the doctors who controlled them, were initially unconvinced of the need for social services. Hospital social work pioneer, Ida Cannon, and visionary physician, Richard Cabot, faced significant resistance from doctors and nurses in their first efforts at Massachusetts General Hospital. However, once the positive impact of assisting patients with the consequences of illness became clearer, hospital social work grew rapidly. Because few of the rampant diseases, such as tuberculosis and syphilis, were curable, social work offered valuable and pragmatic psychosocial assistance (Gehlert 2012). The founders of one Boston-area hospital social work department described their purpose as follows:

...sickness is rarely an isolated fact, but is related to conditions under which people live. Thus the aim of the department is to find out the social causes of the trouble, to cooperate with the hospital in remedying the case, to prevent its recurrence and by doing so, safeguard the community, as well as aid the individual. By rendering social aid, for which the hospital itself has no time, the hospital is saved much expense and the individual and community are greatly benefited (Cambridge Hospital/Mt. Auburn Hospital Social Work Archives n.d.)

Although hospitals were an important venue for early social work, social work in public health—or public health social work, as it came to be known—had its genesis in the community. Local public health departments integrated casework into infectious disease programs to facilitate reaching the “hard to reach,” and promote family coping in the face of job loss and extended hospitalization (Bracht 1978).

In a 1912 presentation to the American Public Health Association, Homer Folks, a sociologist and social welfare advocate, described the alliance between the two emerging fields. Folks noted that community—more than the hospital—was the focal point: “Health officers and
social workers have met because their work brings them to the same place, namely, the home in which there is both communicable disease and poverty” (Folks 1912, 776). Folks’ enthusiasm for how public health and social work could join forces—without turf battles—promoted collaboration in infectious disease control, maternal and child health, and prevention of poverty, which Folks presciently understood as a contributor to disease (Folks 1912).

The successful transdisciplinary campaign to reduce infant mortality serves as the clearest example of social work impact in public health. During an era when women did not yet possess the right to vote, Lillian Wald and Florence Kelley, former settlement house activists, social workers, and civic leaders, successfully advocated for the establishment of the Federal Children’s Bureau. The agency’s purpose was to call attention to women’s and children’s issues, such as shockingly high maternal and infant mortality rates, widespread child labor, orphaning of children, and lack of a comprehensive birth registration system (Almgren, Kemp, and Eisenger 2000).

The Children’s Bureau reflected social work’s growing visibility. Beginning with Julia Lathrop, five of its first directors were social workers, as were many staff. Lathrop directed the Bureau’s first efforts toward building scientific understanding of infant and maternal mortality. Lathrop was outspoken in her belief that infant mortality was not merely, or even primarily, a medical issue, but one that was socially constructed and influenced by preventable social, economic, and family conditions (Combs-Orme 1988). Using an epidemiologically-sophisticated investigation, which included house-to-house field research and prospective surveys in eight cities and rural areas, Bureau workers gathered data. The Bureau released the devastating findings in a series of annual reports and commenced multi-level prevention efforts, reaching deeply into households and communities to raise awareness, promote sanitation, and educate
about health. Simultaneously, the Bureau engaged in vigorous legislative advocacy aimed at garnering federal, state, and local funds for improvement of social conditions (Sable, Schild, and Hipp 2012).

The Bureau epitomized the convergence of social work and public health, helping to define the early characteristics of public health social work: willingness to investigate social factors as causes of poor health; combined use of epidemiologically-informed casework and community-level interventions; and, commitment to political activism to bring about structural change. During the years the Children’s Bureau’s focused on infant mortality, the rate was halved. While many factors contributed to its decline, analyses have affirmed that the Children’s Bureau efforts were key (Almgren, Kemp, and Eisenger 2000).

These early successes, fueled by Children’s Bureau data and political advocacy, set the stage for enactment of the 1921 National Maternity Act, also known as "Sheppard-Towner." Sheppard-Towner provided first-ever federal funding for innovative prevention programming and laid the groundwork for later federal-state collaboration in maternal and child health. The successful reforms, however, fueled accusations of subversion against social workers. Although initially successful in resisting challenges from ultraconservative groups—including the American Medical Association, anti-suffragists, business, and anti-Communist groups—Sheppard-Towner fell victim to allegations of fostering “socialized medicine” and expired in 1929. Nonetheless, social work’s leadership in the establishment of maternal and child health stands as a seminal contribution to public health (Siefert 1983).

**The Professionalization of Social Work**

As social work grew, it branched into sub-disciplines with divergent, often competing
interests and organizations. By 1918, hospital social workers created the American Association of Hospital Social Workers, and like much of the field, became interested in the professionalization of social work (Gehlert 2012). By the 1920’s, a notable split between medical and psychiatric social work occurred, due in large part to the influence of Freudianism and the increasing dominance of casework (Bloom 1981). Medical social work, initially inclusive of all social work in health, began to focus more tightly on casework. Cabot’s original vision had conceptualized social work as the bridge between hospital and community, but gradually, casework increasingly focused on patients’ social and psychological problems (Cowles 2000).

By 1934, the newly-renamed American Association of Medical Social Workers defined medical social work as casework aimed at addressing the relationship between the patient’s disease and social maladjustment (Bartlett 1934). By mid-century, although medical social work continued to articulate a “person-in-environment approach,” the earlier focus on community linkage lessened. Twentieth century advances in curing disease and medical technology strengthened the public’s confidence in hospitals and medicine, and made recovery more attainable. Anxious to secure its role, hospital social work garnered acceptance by adapting to the medical model, embracing its auxiliary role, and focusing on supporting patient recovery within the institution’s walls (Caputi 1978).

Social work in public health grew as well. By the 1920s, social work was integrated into the U.S. Public Health Services (USPHS), providing services that define public health social work today: direct clinical services, case-finding and consultation, program planning, research, training, and prevention within a public health framework. The USPHS expanded social work to include specific roles in heart disease, venereal disease, tuberculosis, and mental illness (Leukefeld 1989).
The devastation of the Great Depression resulted in greater cooperation among disparate social work groups as they struggled to respond. Many labored strenuously for the establishment of a national social welfare system. Some questioned the profession’s evolution in capitalist society, and became active in community organizing, labor unions, radical movements, and politics (Abramovitz 1998). Social workers Harry Hopkins and Francis Perkins, Director of Federal Emergency Relief Administration and Secretary of Labor, respectively, provided key leadership in FDR’s economic stabilization efforts and helped establish the New Deal and Social Security Act of 1935. The prominence of social workers in federal leadership positions enabled the profession to shape the myriad social welfare programs--Maternal and Child Health, Child Welfare, and Crippled Children's Services--that emerged.

Social work expansion continued, during and after World War II, when social workers served in the military, and were integrated into rehabilitation and veterans’ services. By the 1950s, broad federal actions established the National Institutes of Health and the Center for Disease Control, funding health research and treatment, as well as social work (Sable, Schild, and Hipp 2012). As public health and social welfare modernized, social work in public health expanded. Social work developed innovative roles in medical clinics, engaged in the first efforts at disaster and crisis social work, and created “non-traditional” social work in areas such as dentistry (Gwin 1937; Levy, Lambert, and Davis 1980).

As social welfare state functions evolved in the mid-20th century, the profession considered new roles. Prior to the 1960s, most social work in public health focused on secondary prevention; however, interest in primary prevention gradually intensified. Elizabeth Rice, social worker and Harvard School of Public Health Professor, vehemently supported an explicit emphasis on primary prevention and urged social workers to “…understand, solve and prevent
energy health problems).” Like many public health social workers, then and now, she lamented that much of social work still seemed “…to be working on a patient-by-patient basis in clinical services,” neglecting the “potentialities that exist for the more comprehensive practice of social work” (Rice 1959, 88). Milt Wittman argued for a new preventive social work. Wittman, who rose through the ranks of the National Institute of Mental Health, presided over a federal task force on social work education, and was the first social work Professional Liaison Officer for the U.S. Public Health Commissioned Corps, wrote: “The profession stands today at the brink of a vast opportunity to make good its greatest usefulness to society. The field should work diligently to develop…preventive social work…Only in this way can a new generation of social workers learn to apply social work skills in an attack on the roots of social problems. This move is long overdue and should have our serious, considered attention” (Wittman 1961, 28). Despite these appeals, however, public health and prevention were not widely re-integrated into social work education or practice.

The 1960s civil rights and other social movements renewed social work interest in social change and, predictably, tensions resurfaced regarding the profession’s roles. Intense debates surrounded casework; disconnected from social change efforts, some viewed it as ineffectual or destructive (Gilbert and Specht 1974). Other scholars and practitioners engaged in vigorous efforts to reconcile the profession’s efforts in both systems change and service provision. Social workers actively engaged in social initiatives, such as the War on Poverty, the Great Society, and opportunities that accompanied the establishment of Medicaid and Medicare (Reisch 2012). Social work education broadened to include a stronger focus on social problems. The movement to community health—while not wholly advantageous to medical social work—offered public health social work new opportunities (Caputi 1978). Ruth Cowin, Boston-based public health
social worker, observed: “We are in the midst of a social revolution and adaptations in traditional practice…have to be made…experimentation and innovation are the order of the day” (Cowin 1970, 860). She presided over the successful integration of “indigenous workers”—a precursor to community health workers—into a family health center.

Despite substantive advances in education, training, and practice, the idealism associated with Great Society efforts waned as the Vietnam War ground on, and fiscal cutbacks undercut progress in many aspects of social welfare. While social work practice in public health continued, 1970’s disinvestment gutted many innovative programs. As the conservative climate strengthened, the larger profession refocused on advancing clinical social work through licensure, third party reimbursement, and private practice (Reisch 2012).

“Functional Survival”

By the 1980s, escalating health costs unleashed market-driven cost containment efforts throughout the health arena. Lacking the needed data to prove their value, many hospital social work departments were decentralized or eliminated; the roles of hospital-based social workers shifted from counseling toward discharge planning and case management, and some traditional social work tasks moved to allied professionals (Allen and Spitzer 2015). Medical social work entered a protracted phase of self-justification, contracting into a state of functional survival (Silverman 2008).

The turbulence led to a search for solutions, including appeals to redirect the profession towards prevention and public health (Bracht 2000; Rosenberg and Holden, 1999). The USPHS’ Division of Maternal and Child Health held a Public Health Social Work Forward Conference in 1985, to facilitate integration of public health concepts into social work (Ruth, Sisco, and Marshall 2016). Some educators embraced the charge, introducing epidemiology and prevention
into social work education (Bloom 1981). The first MSW/MPH programs were launched, building upon the natural synergies between the fields (Ruth, Sisco, and Marshall 2016). Community prevention partnerships grew, highlighting the value of social work skills in community outreach, cultural responsiveness, and capacity development, and a small body of prevention research emerged (Marshall et al. 2011).

Still, as the millennium approached, there was an unmistakable air of concern regarding social work’s role in public health. When the Institute of Medicine released a major report, *The Future of Public Health* (National Academy of Science 1988), Ruth Knee, a veteran public health social worker who had served in the USPHS and National Institute of Mental Health, was the only social worker to participate in the panel. The report acknowledged broad disarray in the public health field, including funding and workforce issues, lack of coordination with primary care, mental health and social services, and mounting challenges such as AIDS (National Academy of Science 1988). Knee believed that social work, with its proven track record of leadership, had an important role to play in strengthening public health. She urged the profession to more clearly articulate its value and function in public health (Leukefeld 1989).

Yet, many questioned whether the broader field, now heavily focused on therapeutic work with individuals and families, could refocus on public health. Rosenberg and Holden acknowledged the field’s limited understanding of its actual or potential roles: “We urge social work educators, practitioners and researchers to engage in a dialogue to find ways to focus the profession away from pathology and towards prevention, (and) population (health) practice (Rosenberg and Holden 1999, 9).” Bracht, tracing the arc of support for social work in public health and prevention, concluded, “The structural, educational, philosophical and incentive bases
of practice are so ingrained at the individual treatment level as to inhibit either quick or major changes...the ‘will to change’ (first) needs to be rekindled (Bracht 2000, 3).”

**Renewed Interest in Public Health**

As Bracht predicted, the convergence of numerous factors gradually rekindled the profession’s interest in public health. By the century’s end, the nation’s half-million social workers had grown frustrated; they labored within a fragmented system which emphasized disease treatment over prevention, used a maze of bureaucratic structures to contain spiraling costs, produced gross health inequities, and failed to meet a significant portion of their clients’ needs (Marshall et al. 2011, 201). The national tragedy of 9/11, and its ongoing effects, reaffirmed “new” health concerns such as bioterrorism, disasters, and community trauma. Social workers were close witnesses to the changing social, environmental and economic determinants of health, as mental illness, violence, suicide, trauma, chronic disease, and substance use increased. An ever-expanding array of studies highlighted health disparities and articulated the need for upstream social work interventions (Keefe 2010).

Public health’s broadened focus on social sciences, social determinants, and ecological frameworks increasingly engaged social work. Collaborations between the fields expanded to include community-based efforts in substance abuse and HIV prevention; chronic disease management; primary prevention of child abuse; and toxic waste activism (Ruth, Sisco, and Marshall 2016; Turnock 2011). Social work researchers began to systematically employ the powerful tools of public health, such as epidemiology, to inform the profession’s long-standing commitment to serving vulnerable populations (Ruth, Sisco, and Marshall 2016). Major research findings on the impact of adverse childhood experiences, the global burden of mental illness, and potential for prevention of mental disorders, affirmed the profession’s longstanding focus on
trauma and mental health, igniting interest in social work as a preventive force (Hawkins, Shapiro, and Fagin 2010). The U.S. Department of Health and Human Services health goals, known as *Healthy People*, enabled the profession to better locate its work within the nation’s health framework, which in turn, strengthened the growing science of social work (Sable, Schild, and Hipp 2012).

Finally, the enactment of the Affordable Care Act (ACA) issued a clarion call to the profession to once again widen its lens for greater impact. As Reisch notes, the ACA reflects “…a revival of the public health focus that dominated health care and social work a century ago (Reisch 2012, 887).” The “triple aim,” which calls for enhancing access and quality of care, containing costs, and improving population health, rests upon a set of strategies in which social work possesses deep expertise: system integration, care coordination, advocacy, community engagement, prevention, and inter-professional teamwork (Reisch 2012; Spitzer and Davidson 2013). As implementation unfolds, an expanded health social work is both needed and emerging.

**The Bridge: Public Health Social Work**

Public health social work serves as an important base for this new health social work in two critical ways. First, it provides a century’s worth of experience in how to broadly marry clinical, intermediate, and population approaches for greater impact and; second, it serves as the inter-professional bridge between the fields of public health and social work. The rebuilding of this bridge is now evident across a wide range of professional activities: membership has doubled in the Public Health Social Work Section of the American Public Health Association; a new *Social Work in Public Health* journal was launched in 2007; and, prevention has been integrated into educational and practice standards. The American Academy of Social Work and
Social Welfare has established a dozen Grand Challenges for the field, the majority of which require public health approaches.

Some 43 MSW/MPH programs produce graduates who practice within all core public health services, from community mobilization and health promotion, to program evaluation and surveillance (Ruth, Sisco, and Marshall 2016). The integration of public health content into social work is not limited to MSW/MPH programs; a recent review of health content found that 38.5% of MSW programs (n=86) now offer “wide-lens” public health content (Ruth, Wachman, and Marshall 2014).

The Future of Social Work in Public Health

Harry Hopkins may have believed that these two fields were inseparable and in firm possession of common ground, but almost a century later, it appears necessary to remind ourselves of the past and to assess the continuing validity of his assertion. Clearly, social work and public health have much in common: shared Progressive Era roots, a joint commitment to social justice, and a history of collaboration. Yet, despite clear evidence of past and potential synergies between the two fields, social work’s foothold in public health has never been fully established.

This essay suggests some of the historic reasons for social work’s lack of visibility as a public health actor, including choices regarding professionalization, the dominance of clinical interventions, and a failure to articulate its public health history. Despite Hopkin’s perspective, a century ago, it made professional sense to cleave social welfare and health into separate domains. Today, however, efforts to advance health and equity will be undermined if they are not consciously reconnected.
The challenges facing the two fields—health inequities, racism, climate change, violence, mental illness, persistent infectious and chronic diseases, and growing economic inequality—are profound, pressing, and intractable. Even this brief historical review reminds us that changing society at the level of social determinants is never easy and nearly always controversial. As this essay reveals, our predecessors’ resolute efforts to improve health were, by necessity, transdisciplinary, cross-sectoral, political, and closely linked to the expansion of social welfare.

If social work’s past is truly prologue, the stage is now set for an important shift in trajectory. Within a decade, the number of social workers employed in health is expected to swell to 75% of the field. Moreover, those not directly involved in health are already engaged in addressing the social determinants through long-established efforts in housing, education, child welfare, and the promotion of racial social justice. This suggests the need for an important new perspective in social work: “All social work is health work” (Bywaters and Napier 2009, 453). Through this lens, social work emerges as a vast, but underutilized, component of the public health workforce—one whose abilities to engage in community health work, prevention, advocacy, integration, and coalition-building are more essential than ever.

Recently, the American Journal of Public Health debuted a new column dedicated to “a public health of consequence,” focused on what matters now (Galea and Vaughan 2016, 10). As Hopkins knew a hundred years ago, the profession of social work, with its deep roots and ongoing pragmatic presence in public health, is a sister profession of consequence, involved in addressing what matters now. It is time to recognize its historic significance, value its current capabilities and contributions, and provide leadership for expanding its place in the broader public health enterprise.
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