function with authority and resources to implement planning decisions and to enforce conformity with them. Health and hospital planning councils already have been used to establish and enforce standards of need and use in the creation, development, and expansion of health facilities. HSAs will continue to perform this function as decentralized units in a hierarchical system subject to state and federal decisions.

It is debatable whether planning for the operation and funding of health services will continue to be identified with areawide HSAs. The federal government is likely to increase its responsibility for financing health services through some form of national health insurance. As this occurs, operational planning in the health care system will probably be centralized in the federal agency responsible for administering the national health insurance plan.

Thus health and hospital planning may be divided into two categories: one involving the creation and development of health manpower and facilities, and the other, the provision and financing of health care services. Many elements of the health system will continue to be planned through focused voluntary efforts or dispersed individual efforts. However, these will be confined within increasingly stringent, centrally determined parameters. The most effective combination of these various forms of planning will undoubtedly emerge when experience shows which components of the health care system are best planned on a centralized or decentralized basis, and which are best planned at the discretion of individual health-related providers, consumers, and resource groups.

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For related articles, see Community Welfare Councils; Financing Social Welfare: Health Care; Health Care System; other articles on Health Services; articles on Mental Health.

References


Health Services: Maternal and Child Health

A major goal of national and international health organizations is to promote the physical, social, and emotional well-being of mothers and children. In a practical sense this means organizing programs to prevent diseases affecting mothers and children, provide maternity care and related services to
mothers, and treat handicapping conditions of children.

In the United States official responsibility for maternal and child health programs lies with federal, state, and local public health authorities. Contributions to the field of maternal and child health are also made by national voluntary agencies. Public and private hospitals are involved in the provision of community health services to mothers and children. In addition to services specifically directed toward mothers and children, there are many other services provided to families through a variety of special programs such as the Indian Health Service, Neighborhood Health Centers, and the Migrant Health and Appalachian Health projects.

History of Programs

In this country national recognition of responsibility for child health first came about in 1912 with the creation of the U.S. Children's Bureau to "investigate and report on all matters pertaining to the welfare of children and child life among all classes of our people." The first undertaking of the Children's Bureau was a series of studies to determine the causes of infant mortality. These studies showed that the greatest proportion of infant death resulted from remediable conditions existing before birth. Death rates were lower as the incomes of fathers went up. Breast-fed babies and babies with mothers in the home had a better chance for survival; sanitary conditions were significant, and it was said that the community could remedy many conditions dangerous to infants.¹

Studies of maternal mortality included comparisons with services provided in other countries where death rates of mothers and infants were lower. Social and economic factors were recognized as significant in relation to the creation of problems leading to higher rates, and the special risk to babies of unwed mothers was documented.²

The Maternity and Infancy Act (Sheppard-Towner Act) of 1921, administered by the Children's Bureau, was the first national maternal and child health program and the first significant grant-in-aid program in the health field. Activities carried out by the Children's Bureau during the seven years of this program laid the groundwork for development of nationwide maternal and child health programs administered by the states and set the precedent for later federal-state relationships.

Two child health programs, the Maternal and Child Health program and the Crippled Children's program, were created by the Social Security Act of 1935. Both programs provide federal grants-in-aid to the states. Both were administered by the Children's Bureau until 1969, when they were transferred along with the rest of the Children's Bureau health activities to a new agency, the Maternal and Child Health Service in the Public Health Service. The agency now charged with their administration is the Bureau of Community Health Services within the Health Services Administration of the Public Health Service.

Maternal and Child Health Program

The program of maternal and child health set up under the Social Security Act is administered in the states by the official state departments of public health. Maternal and child health programs are concerned with a wide variety of problems. In addition to the traditional services of child health conferences, school health examinations, and health education, they are involved in sex education, poison control centers, comprehensive services for pregnant teenagers, as well as the problems of narcotics addiction and child abuse. The traditional focus of these programs has been on health promotion and prevention with less emphasis on medical care. The programs educate the public on matters of special concern to maternal and child health—prenatal care, child development, dental health, accident prevention, and nutrition. Immunization and public health nursing have always been major components of maternal and child health programs. Setting standards for the

maternity and newborn services of hospitals is a common activity of state maternal and child health staffs.

The special project mechanism was used by the Children’s Bureau to support the development of centers providing for studies, training, and care of premature infants and other new areas of service. One project grant was made in 1952 to enable a state maternal and child health program to develop a statewide program to coordinate medical and social services for unwed mothers. This project was the forerunner of grants made by the Children’s Bureau for demonstration and research in the development of coordinated health, educational, and social services for young unmarried mothers and their infants.

All state health departments have programs that provide medical care of individuals and groups. Title V of the Social Security Act now requires that state health departments provide projects involving maternal and infant care, family planning, comprehensive services for children and youth, dental care for children, and intensive infant nursery care.

The maternal and child health program tends to rely heavily on local rather than state health units, since the nature of the services depends primarily on the particular problems, interests, and resources of city and county health departments. The state primarily provides funds, stimulation, and consultation, and there may be considerable divergence in the services provided in various areas within each state.

**Crippled Children’s Program**

The Crippled Children’s program is essentially a medical care program cast in the frame of reference of public health; it provides preventive services through early detection of handicapping conditions in the total child population of the state. It is administered in each state or territory by a single state agency, usually the state department of health.

The program provides services to children from birth to 21 years of age. By federal regulation diagnostic service is to be provided for children of all races without consideration of financial eligibility or restrictions regarding sources of referral. States may and usually do impose financial eligibility requirements for medical treatment. They determine financial eligibility by a variety of methods that take into consideration the costs of care and each family’s circumstances, with some families paying nothing and others contributing to the cost of care in accordance with their resources.

Patterns of delivery of services vary. Most states employ multidisciplinary staffs to work in clinics and other community health services operated by the crippled children’s program in cooperation with local health departments or hospital outpatient departments. A few rely more on care provided in the offices of private physicians paid by the program. All states purchase care in hospitals, and all set standards for the medical, hospital, and related health services used by their programs.

State programs differ markedly with respect to the diagnostic categories accepted for care. The breadth of coverage is affected not only by the particular interest a state has in handicapped children, but also by its fiscal and professional resources. In state programs for handicapped children in existence before 1935 and in the early years of the crippled children’s program, states accepted children in need of orthopedic and plastic surgery. Major medical problems like poliomyelitis, tuberculosis of the bone, and osteomyelitis, which contributed heavily to their early caseloads, have since been nearly eradicated with new means of prevention and treatment. Medical research has opened up new treatment methods for conditions like congenital heart disease, methods not available in the early years of the crippled children’s program.

In 1939 the Children’s Bureau began to provide funds on a special project basis to enable the states to demonstrate services for children with rheumatic fever. This step was remarkable not only because it resulted in lasting contributions to health services for children with this disease, but also because it was the first use of federal health funds to make grants for special projects.

In two instances the federal government provided funds to develop centers for children with particular problems. Beginning in 1949 regional centers were set up to give children from states without suitable resources the benefits of new developments
in cardiac surgery. These centers continue with federal support for children from states that still do not have the highly skilled teams and complex resources needed. In 1951 centers were set up with federal support for research in the development of prosthetic appliances and services for young children with amputations. One such center continues to provide care of children from those states that cannot provide the full range of services for study and application of medical, social, and engineering knowledge in this field.

Today a few states continue to provide services primarily in connection with orthopedic and plastic surgery. However, most states accept children with a wide range of handicapping conditions.

**Emergency Maternity and Infant Care**

In 1943, Congress appropriated special funds for the Emergency Maternity and Infant Care program (EMIC) to care for the wives and children of servicemen in the lower pay grades of the armed services. The need for this was first recognized in 1941 when the Washington State Health Department, with permission from the Children's Bureau, responded to the request of the Army to use federal maternal and child health funds for this purpose. Such federal funds were used by an increasing number of states in attempts to meet the growing need. EMIC, which continued through World War II, was administered by the Children's Bureau. Federal funds were channeled to state health departments, which provided for these mothers and children, not only by paying for their medical care, but by including them in the regular maternal and child health services of the states. More than 1.2 million women and 230,000 infants were cared for under this program. Undertaken in response to an urgent maternal and child health problem created by war, it continues to be of historical interest to those concerned with systems of providing and financing public medical care.

**Mental Retardation**

In the early 1950s public concern about lack of understanding of the problems of mentally retarded children and their families and lack of adequate services to this group led to increased interest in the potential role of maternal and child health in this field. This interest first took the form of federal grants to several states (California, Hawaii, Washington, and the District of Columbia) to set up multidisciplinary clinics for the diagnosis and treatment of young children who were retarded or suspected of being retarded. Next Congress, primarily as the result of pressure from the National Association for Retarded Children with the help of other voluntary groups interested in retarded children, earmarked maternal and child health funds for mental retardation services. Special clinics in local health departments and hospitals were set up throughout the nation through grants to the state health departments.

It was discovered that early intervention by a multidisciplinary team could solve many of the problems of retardation that had been insoluble by a single discipline. This knowledge, together with new research findings in metabolic diseases and genetics that opened up possibilities for prevention, led to widespread professional interest in maternal and child health services related to retardation. Interest spread beyond the services of clinics to statewide training of the staffs of health and related agencies. Statewide testing programs were instituted for the early detection of phenylketonuria and other diseases that cause mental retardation if not corrected in infancy. State crippled children's programs, some of which had been reluctant to serve mentally retarded children because of their supposedly low potential for rehabilitation, were stimulated by the earmarking of funds for crippled children's services and by their interest in associated handicapping conditions to provide services both for prevention and treatment of mental retardation.

**Special Projects in Maternity and Infant Care**

Interest in prevention of mental retardation also led to the next major addition to maternal and child health services. In 1963, as a result of the report of the President's Panel on Mental Retardation, Congress enacted legislation creating a program of spe-
cial projects for maternity and infant care. This report drew attention to a relationship between poverty, inadequate prenatal care, and the high incidence of premature birth of infants with neurological diseases and mental retardation. Under current legislation these projects provide services related to the prevention of infant mortality and mental retardation.

This legislation made funds available on a special project basis (75 percent federal funds to be matched with 25 percent local funds) to provide comprehensive maternity care to women and health care to their infants up to a year old in low-income areas. Because the legislation originally restricted project grants to state or local health departments, most pregnancy and infant care projects were administered under these auspices. The projects usually provide prenatal care, hospitalization for complications of pregnancy, hospital delivery, postpartum care, family planning, health care of infants, homemakers' services, transportation to and from clinics and hospitals, and the services of public health nurses, social workers, nutritionists, health educators, and other specialists. Efforts are made to link services provided or paid for by maternity and infant care projects with the other health, welfare, and educational services in the community. These coordinated efforts are essential to a comprehensive approach to the total needs of the families served.

The majority of the maternity and infant care projects, and the projects serving the largest numbers of patients, are in urban areas. The population serviced by maternity and infant care projects is characteristic of the urban and rural poor, with a high proportion of patients from ethnic minorities. Young unmarried mothers constitute a high percentage of the caseload, and many projects have initiated or cooperated in developing programs to provide coordinated health, education, and social services for pregnant teenagers. These projects are now administered in every state as components of the maternal and child health program.

**Children and Youth Projects**

In 1965 dissatisfaction with existing child health programs that provided only part of the health services for children of preschool and school age led to the establishment by Congress of a program of special projects for comprehensive health services to children and youth. The first project was approved in 1966. Special project grants that provided 75 percent federal support were available to state and local health departments, to schools of medicine, with participation by schools of dentistry, and to teaching hospitals affiliated with such schools. These projects provide both medical and dental screening, diagnosis, preventive services, treatment, correction of defects, and aftercare. Federal regulations define medical care to include the treatment of emotional problems. The law requires coordination of these health services with other state and local health, welfare, and education programs.

Like the maternity and infant care projects, each children and youth project covers a deprived low-income area. While projects provide services for teenagers, emphasis is usually placed more heavily on younger children. Many hospitals and health departments responded to the availability of funds for these project grants. Because these projects provide for both prevention and treatment, project staffs are stimulated to find ways to organize and deliver services that are typical of public health departments, combined with those typical of hospitals and their outpatient departments. Through these projects some health departments have added medical care services for children. Some hospitals have had to make fundamental changes in their operations to reach into the community to find and hold patients and groups of patients under care.

Several of the children and youth projects are currently providing leadership in community activities to prevent lead poisoning in children through improvement of housing conditions. These projects have also provided staff to assist residents of their service areas with a wide variety of community efforts, not only to prevent specific health problems, but to help fulfill the total health needs of the population. Many of these projects are notable for their effective use of staff with various levels of training to provide services under appropriate professional supervision, for their progress in consumer participation, and for their ef-
forts to find new methods of delivering health services. A national continuous study has been instituted to determine the effectiveness of these projects in achieving comprehensive health care.

These projects also are now administered as required components of the state maternal and child health programs.

**Family Planning**

State programs in the southeastern United States pioneered in the development of family planning as an integral part of maternal and child health services. The first such development began in North Carolina in 1937. When the maternity and infant care projects got under way in the mid-1960s, many began immediately to include such services, either by providing them directly or through referrals to other community agencies. The experience of these programs in providing family planning services has been used as a major source of data for national planning and congressional action in this field.

Special projects for the development of family planning services were created by congressional action in 1967 and first assigned to the Children's Bureau for administration. Major responsibility for administration of project grants for family planning now rests with the National Center for Family Planning, but maternal and child health programs of the states, together with special projects for service and research supported with federal maternal and child health funds, continue to provide their family planning services as a part of family health services. Family planning is now a required component of the state maternal and child health programs.

**Hemophilia and Genetics Services**

Legislation passed in 1976 created a new program for the support of regional centers providing specialized knowledge and skills in the care of hemophilic patients. The program, which requires collaboration with state crippled children services, is administered by the Bureau of Community Health of the Health Services Administration. Seventeen centers were funded in 1976.

Other legislation in 1976 created a program for support of genetic testing, counseling, information, and education. The law specifically mentions "genetic diseases, including sickle-cell anemia, Cooley's anemia, Tay-Sachs disease, cystic fibrosis, dystrophia myotonica, hemophilia, retinitis pigmentosa, Huntington's chorea, and muscular dystrophy." This program is also administered by the Bureau of Community Health Services, in cooperation with the Public Health Service Center for Disease Control, and is expected to become part of each state's official maternal and child health program.

**Training in Maternal and Child Health**

Schools of public health provide specialized training in maternal and child health to a variety of students who have completed professional education in their own disciplines. Content related to maternal and child health is included in the basic curricula or in special advanced programs for many of the professions involved in maternal and child health services. Federal maternal and child health funds are used to strengthen maternal and child health teaching through faculty support and stipends for training in such fields as public health, nursing, social work, nutrition, psychology, speech and hearing, physical and occupational therapy, dentistry, and a variety of related medical specialties and sub-specialties. A new emphasis, brought about in 1965 through new legislation and appropriations specifically intended for training of personnel for maternal and child health, is on special project grants to institutions of higher learning to prepare students for interdisciplinary practice especially related to services for multihandicapped and mentally retarded children. To accomplish this goal in interdisciplinary training these projects have developed interdepartmental agreements within their own universities and with schools and departments of other universities. Twenty-one of these university-affiliated projects were being supported by maternal and child health training grants in 1976. A program to train personnel for the care of children with pulmonary diseases is carried out through regional pediatric pulmonary centers, which specialize in treatment of cystic fibrosis, asthma, and
other pulmonary disorders affecting infants and children. Eleven such centers were supported by federal funds in 1976.

Research

Until 1963 no federal funds were appropriated specifically for research in maternal and child health. In that year Congress provided for a National Institute of Child Health and Human Development to be added to the National Institutes of Health in the Public Health Service and for a program of research in maternal and child health and crippled children's services. The latter, first administered by the Children's Bureau as a part of its child health responsibilities, was later transferred to the Public Health Service. The National Institute for Child Health and Human Development has major responsibility for basic research, and the maternal and child health program for program-related research in maternal and child health. National voluntary agencies such as the National Foundation and United Cerebral Palsy continue to support research related to maternal and child health.

Role of Social Workers

Social workers played leading roles in the activities that preceded and followed the creation of the Children's Bureau. Their interest and involvement had a significant influence on the passage of the Sheppard-Towner Act and on the decision to place responsibility for its administration in the hands of the Children's Bureau. The social work profession was also deeply involved in the passage of the Social Security Act. Questions raised with the Children's Bureau by a committee of the American Association of Medical Social Workers led to the inclusion of social work staff to participate in administration of the maternal and child health programs created by this act. Federal guidelines for the states called for the inclusion of medical social workers in the multidisciplinary staffing required to administer state maternal and child health and crippled children's programs.

Although social workers were involved in developing and supporting legislation for maternal and child health and were employed in the maternity and pediatrics departments of hospitals, they were first employed in community health services for mothers and children after the passage of the Social Security Act. This also marked their first nationwide employment in official public health programs.

Social workers were brought into maternal and child health programs to apply their special knowledge and skills to the total planning, organization, and delivery of health services for mothers and children. Knowledge and skill in identifying and dealing with social needs of mothers and children, understanding of the dynamics of human relationships, knowledge of available community services, and ability to organize social services were major contributions of social work from the outset.

In 1935 only one state and one local health department had social work staff. Under the impetus of federal leadership social work staff was rapidly added in state programs. This was particularly true in services to handicapped children, because of the similarity of these services to those traditionally provided in the hospitals from which the social workers and their colleagues of other disciplines came. While there were a great number of social workers throughout the country, often only one or two in a state were involved in bringing the influence of social work to bear upon broad health programs for the total population and were responsible for medical services to hundreds of children in all parts of the state. In 1937 the unique problems of these workers led the medical social work unit of the Children's Bureau to begin calling together the social work staff in these state programs for annual conferences to share experiences and discuss mutual problems peculiar to the new field of social work in public health. These conferences have expanded and continue to emphasize maternal and child health content, although they are open to all social workers in federal, state, and local public health departments and related hospital services.

Many more social workers were added to state maternal and child health programs with the introduction of the Emergency Maternity and Infant Care program in 1943. Social workers had played a significant role in the planning of this program. Since federal guidelines directed that state
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plans for EMIC were to include medical social services, social workers were able to help the thousands of pregnant women, married and unmarried, who were stranded far from home near the military bases from which the fathers of their babies were being shipped overseas.

In the 1950s social workers, both within and outside the government, had much to do with the development of maternal and child health services for mentally retarded children. Unlike earlier program developments, which had led primarily to the creation or expansion of social work staff in state-level positions, early emphasis on the development of special clinics in this program resulted in the creation of many social work positions in local health departments and in hospitals whose clinics were supported by maternal and child health funds. Social workers in these maternal and child health programs have played major roles in promoting interest in mental retardation and have carried their interest into the area of professional education in maternal and child health for social workers and other disciplines.

In 1963 the creation of a program of special projects for maternity and infant care gave social workers the opportunity for practice in a program that serves social and medical needs and began to bring many more social workers into maternal and child health positions. Many more who were not actually employed in project positions have become closely involved because of the necessary linkages of health departments, hospitals, schools, and social agencies. Of particular concern to social work are the linkages with community agencies to assure attention to the health, educational, and social needs of pregnant teenagers.

Similarly, the opportunity to practice in a community-oriented program and to try out new methods for the delivery of child health services has attracted many social workers to children and youth projects since their creation in 1965. These projects have clearly demonstrated that social services must be provided to solve basic social problems that the people who are being served may think are more important than the actual health services, particularly the preventive health services, the projects would like to provide. Social services are being studied as a part of the total operation of projects to determine the effects of program operations on the achievement of child health goals. The need for social services to patients being served by maternity and infant care and children and youth projects resulted in the development of these services in some hospitals as well as health departments that had not had departments of social work.

Until family planning was introduced in maternity and infant care projects, only a few social workers in child health programs involved in genetic counseling for parents of handicapped children and social work staff of Planned Parenthood were concerned with family planning. The lack of interest and knowledge in all fields of social work practice and education was considered so serious by a committee of social workers associated with the Maternal and Child Health Association, that a national conference on family planning and social work was held in 1967. Some social workers are employed full time in family planning, but many more contribute to this service through their work in more comprehensive services related to maternity or teenage health services. Other preventive services in which social workers are increasingly involved include direct intervention and program planning and research related to perinatal and neonatal care, child abuse, prenatal diagnosis, and genetic counseling.

Changes in public attitudes and in state abortion laws are of special concern to social workers in maternal and child health services, many of whom are being called upon to help develop agency policies and to provide social casework in connection with this rapidly expanding medical service.

In accordance with early standards set by the Children’s Bureau and later by the American Public Health Association in cooperation with the Council on Social Work Education, most social work positions in public health require an MSW degree. A small but growing number of social workers, particularly those engaged in teaching maternal and child health in professional schools, also have master's degrees in public health. Social work assistants are being used increasingly in programs and projects providing direct services to people. They carry out social services that do not require full professional training under the supervision of fully qualified social work staff.
All methods of social work are utilized in maternal and child health. As is generally true for all social work practice in public health, most positions require skill in several different methods. Administration of social services together with program analysis, program planning, community organization, and technical consultation for the development of maternal and child health services, research, and training are carried out in cooperation with other disciplines by social work staff in the federal maternal and child health programs and by the chiefs of social services in state and local maternal and child health programs.

The process of consultation developing from the early days of social work in maternal and child health is utilized at all levels, with emphasis on program consultation in federal and state programs that do not provide direct services to people and on case consultation in programs that do provide such services. Social casework services and, to an increasing extent, group work services, are provided as a part of direct health services. Other social work activities less readily classified in traditional terms help groups of patients, parents, and members of the community to understand and make effective use of health services and to take action to bring about necessary changes in community services.

Social workers in hospitals have long been associated with treatment services for the mothers and children who are of particular concern to maternal and child health programs. Through support of special projects and purchase of hospital care, many of these workers have been paid indirectly by public health programs. Today social workers employed by hospitals are assuming more responsibility for service in community health programs that provide prevention as well as treatment. School social workers and staff members of social agencies have necessarily become more involved as new health programs provide comprehensive services for mothers and children. Even some staff of closely related voluntary social agencies are paid from child health funds. There are social work faculty members in schools of medicine, public health, and social work engaged full time in teaching and research in maternal and child health.

State maternal and child health and crippled children's programs may use federal funds for the training of social workers as well as other disciplines employed in maternal and child health services. Since 1947 some federal maternal and child health and crippled children's funds have been used to support special projects in a few graduate schools of social work with special interest in health services to children. Project grants also support maternal and child health training of social workers in schools of public health. A growing number of social work students and faculty are involved in education in maternal and child health through the affiliations of schools of social work with other professional schools and departments of universities carrying out the projects for interdisciplinary training of personnel for maternal and child health services. Grants are also made to universities for short-term training to help social workers keep abreast of new knowledge relevant to practice. Publications are developed by these projects and given nationwide distribution.

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For related articles, see CHILD WELFARE; CHILD WELFARE: INSTITUTIONS FOR CHILDREN; HEALTH: WOMEN; articles on Health Care Systems; other articles on Health Services; HOMEMAKER-HOME HEALTH AIDE SERVICES; articles or Mental Health; NUTRITION.

References


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**HEALTH SERVICES:**

**PUBLIC HEALTH PROGRAMS**

Public health, like social work, is a dynamic and evolving field. Both fields, by their very nature, must constantly adjust their definitions, parameters and perimeters, and even their methods, to be responsive to society’s changing needs and the cultural milieu. However, social institutions—of which public health is one—are not notable for their alacrity of adaptation. Thus cultural lag is evident in the ever evolving field of public health.

**Definition**

Public health can be defined in broad terms, even though its more specific focuses alter with time and place. Drawing on the recent definition given by the Milbank Memorial Fund Commission for the Study of Higher Education for Public Health, public health can be said to encompass those activities that organized societal entities (both governmental and nongovernmental) deliberately conduct to protect, promote, and restore the health and quality of life of the people on a broad community or population basis.

Certain key distinctions should be noted. Individual physicians, clinical psychologists, social workers, and other therapists working privately with individual patients or clients can be acknowledged as performing functions that contribute to public health, but cannot thereby be described as functioning—other than peripherally—in the public health arena. An organized medical group may attend to the health needs of a subscribing clientele, may even be recognized as a “health maintenance organization” that clearly addresses the health of an identified “public,” and yet may not be so publicly available as to fit into the central public health concept. The line, to be sure, may become thin. For example, the Group Health Association of Washington, D.C., a prepaid medical group practice plan, provides clinical services to 100,000 members of the Washington, D.C., community and even chooses to be an organizational member of the American Public Health Association, but it is not therefore to be classified literally or primarily as a public health organization. The reason is that the Group Health Association’s concern is with selected individuals (who happen to number 100,000), rather than with the whole community as a community. This distinction also excludes such organizations as pharmaceutical firms, community pharmacies, and nursing homes from classification as public health organizations. To the extent that they are profit seeking and accessible to individuals rather than to the broad community, such organizations can be said to contribute to the community’s health without being integral members of the public health enterprise.

**Fundamental Concepts**

The community orientation is, therefore, basic to public health. In that and other

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