harm and maximize their functioning in all areas of living.

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For further information, see Drug Use and Abuse; Mental Health Services; Values and Ethics.

References


PUBLIC ASSISTANCE. See Aid to Families with Dependent Children; Food Stamp Program; General and Emergency Assistance; Income Maintenance System; Quality Control in Income Maintenance; Social Security.

PUBLIC HEALTH SERVICES

Public health social work services include prevention, diagnosis, treatment, maintenance, and rehabilitation. These services are provided in a variety of settings such as public health programs, general and specialty hospitals, nursing homes, community health centers, community mental health centers, and hospices (National Association of Social Workers [NASW], 1981).
In addition to traditional public health programs carried out by federal, state, county, and local government agencies, voluntary agencies incorporate policies that parallel public health goals. Social workers in public health services provide direct services including casework, group work, and community organization as well as administration, management, prevention, research, and epidemiological services.

A common definition of public health was developed by Winslow in 1920 (cited in NASW, 1981):

Public Health is the science and art of (1) preventing diseases, (2) prolonging life, and (3) promoting health and efficiency through organized community effort for: (a) the sanitation of the environment, (b) the control of communicable infections, (c) the education of the individual in personal hygiene, (d) the organization of medical and nursing services for the prevention and treatment of diseases, and (e) the development of social machinery to insure everyone a standard of living adequate for the maintenance of health...[and] so organizing these benefits as to enable every citizen to realize his birthright of health and longevity. (p. 12)

This definition of public health provides a backdrop for social work's person-in-situation and community interventions—depicted in this definition as "social machinery"—as well as the traditional public health concepts of host, agent, and environment as a focus for interventions.

This article provides an overview of public health services and the role of social work in this area. It includes a brief historical overview, the organization of public health services at the federal level with an emphasis on the U.S. Public Health Service, and practice issues.

Public health services are concerned with the prevention and control of disease. Prevention is usually divided into three areas—primary, secondary, and tertiary prevention—which is a useful concept for considering public health social work. Primary prevention includes preventive interventions initiated before the onset of disease. Secondary prevention includes early interventions focused on initial onset, and tertiary prevention includes interventions focused on treatment. As can be seen in these definitions, public health social work clearly overlaps with medical social work. To provide a clearer conceptualization, however, medical social work is included as part of public health social work.

History

The history of public health social work is intertwined at the federal level with the U.S. Public Health Service (PHS) (Biema, Stein, & Biema, 1983; Furman, 1973; Williams, 1951). The Public Health Service originated as the U.S. Marine Hospital Service when, on July 16, 1798, President John Adams signed an Act of Congress that provided for the first tripartite health care program in the United States. The U.S. Marine Hospital Service called for tripartite contributions from the federal government, the merchants responsible for shipping, and a contribution of 20 cents a month from each merchant seaman.

With the passage of the National Quarantine Act of 1889, the federal government moved toward broader health protection for the country, which continues to this day. After 1912, when the U.S. Marine Hospital Service was renamed the Public Health Service, both health services delivery and health protection coverage increased in the United States. A parallel expansion of social work in health care occurred at the same time as social workers were integrated into most federal public health activities (Kerson, 1979).

Kerson (1979) identifies 1918 as the year of "juncture" in the development of social work in health care. In May 1918, medical social workers organized the American Association of Hospital Social Workers, which is considered the formal beginning of medical and public health social work. While public health social workers were treating World War I veterans, both tuberculosis and venereal disease were increasing in the general population. Social workers were involved with families in working to keep these diseases from spreading. During this early period, paid and volunteer staff frequently worked together as equals, and the American Red Cross played a major role in the provision of social services (Kendall, 1982). After an era of specialization in the social work profession, things began to change. This change was reflected in 1955 when the National Association of Social Workers was formed and emphasis was placed on generic...
social work. The medical social work specialty was lost. However, the interest was reborn when the American Society for Hospital Social Work Directors was formed in the mid-1960s (Kerson, 1979).

Public Health Social Work at the Federal Level

Professional social work began in the U.S. Public Health Service when Elizabeth G. Gardiner was employed as the first social worker assigned to the U.S. Marine Hospital at Ellis Island in New York City on July 1, 1921. Additional social workers were added to the service in the 1920s to provide outpatient social services. It was not until World War II that social workers were broadly employed by the War Shipping Administration to provide service to patients in the PHS Marine hospitals and clinics. Following a formal reorganization in 1944 of the Hospital Division, which was responsible for hospitals, medical social work was incorporated into all hospital planning. American Red Cross workers who provided social services were replaced with medical social workers, and since 1949, all social workers have been paid by the Public Health Service. Social work services spread throughout the various functions and organizational components of the PHS including its Hospital Division, headquarters staff of the Division of Chronic Disease, community services, training, and planning. Social workers were also employed to provide consultation and technical assistance to states, local health departments, hospitals, and communities (Wittman & Kissel, 1979).

The PHS Commissioned Corps was established formally by Congress in 1889 along military lines with rank and pay corresponding to military grades. As one of the seven uniformed services of the United States, the PHS Commissioned Corps is a health-related professional personnel system established as a mobile health force. In 1949, Daniel O'Keefe became the first PHS social work commissioned officer.

An important milestone for public health social work came in 1966 when John Gardner, then Secretary of the Department of Health, Education, and Welfare (HEW), established the Council for Career Development, which was responsible for career planning, under the direction of Under Secretary Wilbur J. Cohen, a member of the Academy of Certified Social Workers (ACSW). Milton Wittman was designated as the PHS's representative to the Career Board for Social Work, and in 1978 Wittman was designated the first Professional Social Work Liaison Officer for the PHS. By 1967, the PHS's use of social workers had increased to about 250, and in 1968 the Public Health Social Work Career Development Program was established. That same year Under Secretary Cohen became the first ACSW member to be appointed Secretary of HEW (Wittman & Kissel, 1979).

In 1973, the health functions of the Children's Bureau were transferred to the PHS. Social workers were functioning in child health programs administered by the Children's Bureau, which was established in 1912. Since the transfer, social workers have contributed to policy and program development in Maternal and Child Health Services and other programs in the PHS.

By the late 1970s and early 1980s, social workers provided services in both medical and community mental health programs as well as health planning, research, and management. With emphasis on self-determination for American Indians, many of the trained public health social work staff are now from various American Indian tribes. In addition, American Indians and Alaska Natives have been trained as mental health workers and medical social work associates. During the 1970s and 1980s, PHS social workers grew in number to over 600.

These federal developments were paralleled by similar ones in state, county, and local health departments, which integrated public health social work into their activities. These major developments were most noteworthy in larger eastern states, however.

Public Health Social Work Practice

The number of social workers engaged in public health social work practice is best estimated by using the most recent NASW membership survey. The 1982 National Association of Social Workers membership survey ("Membership Survey Shows Practice Shifts," 1983) indicated that—of those individuals who responded—47.6 percent were engaged in public health social work activities. In other words, when the practice groups identified by NASW are combined to
form a public health social work practice group, they represent a substantial number of NASW members. The specific NASW membership practice areas and the percentage of respondents by group were medical or health care, 18.1 percent; mental health, 26.6 percent; and alcohol/drug substance abuse, 2.9 percent. These three specific groups represent the broad areas of public health practice. The 47.6 percent figure also represents over 47,000 social workers or almost half of the nearly 100,000 NASW members. Thus, almost half of NASW social workers indicated that they are involved in health-related social work.

As outlined and defined by Rice (1959), the functions of public health social work include: consultation, social casework skills, educational services, program planning, and policy formulation as well as community planning and research. This distinguishing of public health social work from medical social work emphasizes the importance of the community and of practice in the public arena. Spencer (1965), in a later conceptualization of public health social work, underscores the notion that consultation is a major activity and that public health social work builds on casework skills as the foundation of social work services. Spencer (1965) also outlines the social worker’s role in health departments as: standard setting and surveillance of quality care; developing tools to measure individual and family social functioning; participating in data collection activities; critiquing of program plans and projects; social research and demonstration planning and implementation; participating in the assessment; computing social illness costs; and joint programming.

Public health social workers who practice in public health organizations become familiar with both prevention and the epidemiologic approach. The degree of prevention effectiveness is often a key issue for public health social workers. To state this differently—and probably exaggerate the issue to some degree—this disagreement can be described as a schism between practitioners, who sense their accomplishment as well as their effectiveness, and researchers, who base effectiveness on controlled studies that validate the effectiveness of prevention interventions.

Public health social workers increasingly realize the necessity of acknowledging the importance of the effectiveness issue by planning prevention programs that include research designs for information gathering, explicating variables, describing interventions, including pretests and posttests, sampling designs, and longitudinal followup. The minimum specific information might include data regarding the number of individuals who enter the program and their socioeconomic status characteristics, what happens to these individuals in the program or activity, how long clients have been exposed, and when they leave or complete the program. Many practitioners who suggest that they do not understand research nevertheless base their practice interventions in large part on evaluation, assessment, clear understanding, and feedback.

The primary research guide and approach used in public health is epidemiology, whose application to public health social work has been described by Battle (1985). Epidemiology is concerned with determining populations at risk of medical disease (such as AIDS) and behavioral disorders (such as substance abuse). It includes an examination of incidence (the number of new cases) as well as prevalence (the number of individuals with the problem). The epidemiologic approach, when applied by public health social workers, involves an understanding of the nature of diseases as well as their incidence and types. In addition, epidemiology fits well with the systems approach to social work practice.

The NASW Standards for Social Work in Health Care Settings provide the professional basis for practice in health care settings (NASW, 1981). These are both core and specific standards that describe specific organizational responsibilities for social work in health settings. Core standards include education level, supervision, the number of qualified social workers, function, planning objectives, policies, procedures, quality, physical aspects, and setting. Health protection/promotion, planning and collaboration form the three keystones for specific public health standards.

Bracht (1978) provided a concise statement and description of public health social work along with bibliographical references. The public health practice function he lists are case finding and planning, outreach of
team members, preventive casework, leading discussion or organizing client/patient groups, planning or advocacy, case or program consulting, helping to establish policies and procedures, assessing social and health needs with consumer groups, research and evaluation, and participating in training and staff development. Most important, he identified three major practice strategies in public health: (1) prevention using epidemiology, that is, using statistical procedures and demographic information to determine the incidence and prevalence of disease to plan prevention interventions, (2) community health, that is, using procedures to better understand community health and interventions, and (3) health planning, or planning interventions and practice. These three strategies are major approaches used by social workers in public health social work interventions.

In the area of maternal and child health care, emphasis has been placed on family and prevention (Hall, St. Denis, & Young, 1983), the family in health care (Gitterman, 1983), and children and youths with handicapping conditions (Riehman & Reichert, 1982). The area of public health social work is rich with practice resources and references related to approaches and methods, including three journals, Social Work in Health Care, Social Work, and Health and Social Work.

Public Health Service Today

The Public Health Service of the 1980s is different from that which existed in 1921 when professional social work was formalized within it. The service changed in response to shifts in the recognized health needs of the country. Services have expanded with the growth of federal responsibility for health needs. Major milestones (Public Health Service Office, 1984) include:

- In 1935, passage of the Social Security Act authorized health grants to states and aided efforts by PHS to organize and develop the nation's health resources. In effect, this legislation united the federal government and the states in a partnership to promote and protect the health of the American people.

- In 1937, passage of the National Cancer Act established the National Cancer Institute and set a national pattern for support of biomedical research.

- In 1938, with the passage of the General Disease Control Act, the first of many national disease control programs was launched.

- During World War II, the PHS carried out emergency health and sanitation measures that contributed substantially to the organization and development of the nation's health resources.

- In 1946, in response to a critical shortage of medical facilities, the National Hospital Survey and Construction Program—known as the Hill-Barton Program—was established. It provided for federal aid to the states for building hospitals and health centers. That same year, the National Mental Health Act established a broad program of grants for research and training and became the basis for community mental health services.

- In 1953, PHS, with other components of the Federal Security Agency, became part of the newly created Department of Health, Education, and Welfare.

- In 1955, responsibility for the health care of American Indians and Alaska Natives was transferred from the Department of the Interior to the PHS.

- In 1961, the Community Health Services and Facilities Act authorized the PHS to support community studies and demonstrations that would lead to new and improved out-of-hospital services, particularly for the chronically ill and aged.

- In 1962, the Vaccination Assistance Act enabled PHS to help states and communities conduct immunization programs against poliomyelitis, tetanus, diphtheria, and whooping cough.

- In 1963, the Mental Retardation Facilities and Community Mental Health Centers Construction Act extended the service-development concept to the mentally ill and retarded, emphasizing treatment in patients' communities rather than custodial care in large institutions.

- The Health Professions Educational Assistance Act of 1963 and the Nurse Training Act of 1964 enabled PHS to begin to meet the shortage of health professionals.

- In January 1964, the publication of Smoking and Health, Report of the Advisory Committee to the Surgeon General of the Public Health Service signaled the beginning of increased publicity on the health hazards of smoking.

- In 1974, the Public Health Service
began to administer the National Health Planning and Resources Development Act and to work with states and local communities to identify and plan the health services needed by communities throughout the country.

■ With formation of the new U.S. Department of Education in 1979, PHS became part of the newly created Department of Health and Human Services.

■ Also, in 1979, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention was released. This report outlined national health goals for 1990.

■ In 1980, the Public Health Service published Women and Health, a report documenting a broad range of health issues that are either unique or of special importance to women. In 1984, a Task Force on Women’s Health was established to assure that these issues would be addressed.

■ In 1982, categorical health services funds were placed into block grants to states, which became responsible for federal health services funding.

Public Health Service Organization

At the federal level, the Public Health Service is composed of five agencies and several offices. At the beginning of 1984, the Public Health Service employed about 42,900 civil service workers and 5,000 officers of the Public Health Service Commissioned Corps. The PHS budget in Fiscal Year 1984 was approximately $8.1 billion. The five major agencies are:

National Institutes of Health (NIH). Located in Bethesda, Maryland, NIH is one of the major biomedical research centers in the world. It conducts research in its own laboratories, funds research in the United States and abroad, supports the training of promising new researchers, and communicates research results to scientists, health practitioners, and the public. It is made up of 11 specific research institutes. In addition, the Clinical Center serves as a focal point for patient care research, including the Social Work Department. NIH also provides funding for research grants that enable scientists to examine the psychosocial aspects of disease, health, and prevention.

Food and Drug Administration (FDA). Located in Rockville, Maryland, and Washington, D.C., FDA is a regulatory agency that acts to ensure that the nation’s food is safe, pure, and wholesome; that human and animal drugs, biologic products, and therapeutic devices are safe and effective; that cosmetics are harmless; and that electronic products do not expose users to dangerous amounts of radiation.

Centers for Disease Control (CDC). Located in Atlanta, Georgia, CDC develops and conducts programs for disease prevention and control, environmental health, occupational safety and health, health promotion and education, and the training of health workers.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Located in Rockville, Maryland, ADAMHA seeks to control and prevent alcohol abuse and alcoholism, drug abuse, and mental and emotional illness by conducting research in intramural laboratories and supporting extramural research. In addition, ADAMHA funds extramural research that examines the psychosocial aspects of alcohol, drug abuse, and mental health.

Health Resources and Services Administration (HRSA). Located in Rockville, Maryland, HRSA in cooperation with national, state, and local organizations, seeks to maintain and strengthen the supply, distribution, and utilization of health care resources and to ensure the delivery of primary health care services, preventive health services, and other specialized care to medically underserved populations through program activities like the Indian Health Service and to other groups with special health needs.

Prevention

A major issue in public health is the focus on prevention. That focus is based partly on economics and partly on the current emphasis on healthy lifestyles. The economic focus is the result of health care spending in the United States having grown to an estimated $322 billion in 1982. That is about 10.5 percent of all goods and services produced in this country or 10.5 percent of the gross national product (GNP). In addition, medical
costs were 12.5 percent higher in 1982 than in 1981 and grew three times faster than the GNP. This increase relative to the GNP was the largest percentage increase ever recorded. In contrast, in 1965 health care spending represented only about 6 percent of the GNP. In 1982 it represented over twice as much.

Analysts and many others are questioning these expanding costs and suggesting that they must be contained. Methods to reduce health care costs are now in the experimental phase. In addition, public health officials are proposing lifestyle modification as a major approach to reducing health care costs. Social workers have long known that changing attitudes and behavior is a difficult process, however, one that requires motivation, in this case motivation to engage in healthy behavior.

A Surgeon General’s report on health promotion and disease prevention (U.S. Department of Health, Education, & Welfare, 1979) outlines health goals for the nation that can be achieved by the end of the 1980s. Following publication of this report, experts worked in a year-long effort to draft measurable objectives for the nation in 15 priority areas singled out by the report: high blood pressure control, family planning, pregnancy and infant health, immunization, sexually transmitted diseases, toxic agent control, occupational safety and health, accident prevention and injury control, fluoridation and dental health, surveillance and control of infectious diseases, smoking and health, misuse of alcohol and drugs, nutrition, physical fitness and exercise, and control of stress and violent behavior. These objectives have provided the framework for national efforts to improve the health of Americans during this decade.

The major theme of the Surgeon General’s report is that prevention is an idea whose time has come. It indicates that the American people are interested in improving their health. Increased attention is being paid to exercise, nutrition, environmental health, and occupational safety. Based on an analysis of the 10 leading causes of death in 1976, the report indicates that perhaps as much as half of all U.S. mortality was due to lifestyle.

The major factors responsible for most of the premature morbidity and mortality are cigarette smoking, misuse of alcohol and drugs, occupational risks, and highway and home injuries.

The report identified six areas of behavior that, if modified, will affect health status. The behavior to be adopted includes: (1) stopping cigarette smoking, (2) reducing alcohol misuse, (3) moderating dietary habits to reduce intake of excess calories, fat, salt, and sugar, (4) engaging in moderate exercise, (5) obtaining periodic screening for major disorders such as high blood pressure and certain cancers, and (6) adhering to speed laws and wearing seat belts.

Lifestyle modification is not a pleasant issue to deal with for many individuals. Often, indicated behavior is strongly associated with pleasurable experiences and raises the question of what life would be like without any of these “pleasures.” The issue of modifying individual lifestyles will become more important for public health in the next decade.

Cigarette smoking, a major public health problem today, readily serves to illustrate the public’s interest in reducing the health costs—both financial and personal—associated with individual lifestyles. Cigarette smoking is responsible each year for more than 340,000 premature deaths, at least $13 billion in health care expenses, and $3 to $4 billion in Medicare and Medicaid costs. The Surgeon General has stated that cigarette smoking is the most preventable cause of death in the United States (personal communication). It represents the kind of health care cost that can be drastically reduced by modifying personal behavior.

The Princeton Public Health Social Work Conference, held in New Jersey in 1962, provided a focus for public health education in social work, especially concerning prevention (CSWE & HEW, 1962). Specific considerations for public health social work based on the concepts developed at the Princeton conference include: (1) prevention is more than crisis intervention, (2) the family is a major focus for prevention, (3) family life education/skills building is a preventive intervention that should receive wider application by social workers, (4) self-help groups and mutual support networks are excellent preventive interventions, and (5) education is part of the social work/client responsibility.
Future of Public Health Social Work

The future of public health social work reflects those issues discussed previously. In the light of growing fiscal pressures, Black (1984) argues that two areas can be identified as presenting opportunities for social work's creativity and leadership in public health: (1) reclaiming social work's focus on community health, and (2) providing clinical services for individuals facing complex decisions about values and lifestyle with the advent of modern technology.

Fiscal pressures will affect all aspects of social work, including public health. A major issue is: How will public health social work change as part of the shifting environment or to what extent will public health social work be able to modify environments? Developing sound cost-benefit information will be a major goal. A cost-benefit approach should at a minimum include specific settings as well as identified providers. Public health social work is in a unique position to guide the formulation of this blueprint.

Microcomputers and linked data systems will make the manipulation and analysis of data concerning both incidence and prevalence less costly and more usable. This accessibility will bring the epidemiologic approach within easier reach of practitioners and students.

Schools of social work have expanded their emphasis on health and public health. A survey by Caroff and Mallick (1985) reported—with findings collected from 72 of the 85 graduate schools of social work—that 58 percent of the responding schools had health concentrations and over 8,000 students received education in the 72 schools. In addition, Caroff and Mallick found that these concentrations were a relatively new development with the largest increase in new concentrations between 1978 and 1979, when 18 new health concentration programs were added. They also found that health-specific courses were clustered in the areas of direct practice; policy and planning; psychosocial aspects of health; platform skills, which included introductory health courses and integrative seminars; and miscellaneous.

Promising research developments will provide additional information for public health social work. Information has already changed lifestyles and behaviors with a promise for behavioral as well as technological advances. Social work is also placing more emphasis on research with initiatives by both CSWE and NASW. However, the extent to which these efforts will include public health social work issues remains both open and promising.

Finally, public health social work is on the cutting edge of prevention, yet the professional literature does not systematically reflect that emphasis. In one sense, prevention is home without a structure. However, it can be argued that public health social work is developing theory, assessing interventions, and refining themes. A subject for consideration is the development of possible models for practice and carrying out research in the area of wellness. Ng and Davis (1981) have developed a model by expanding the illness-wellness continuum. They suggest that there are two distinct continuums: (1) wellness and no wellness, and (2) illness and no illness. This model presents a conceptualization for public health social work practice intervention that emphasizes prevention and provides a possible framework for the direction of public health social work.

CARL G. LEUKEFELD

For further information, see FEDERAL SOCIAL LEGISLATION SINCE 1961; HEALTH PLANNING; HEALTH SERVICE SYSTEM; HOSPITAL SOCIAL WORK; LONG-TERM CARE; MENTAL HEALTH SERVICES; PREVENTIVE HEALTH CARE AND WELLNESS; PRIMARY HEALTH CARE.

References


For Further Reading


PUBLIC HOUSING. See HOMELESSNESS; HOUSING; SOCIAL PLANNING AND COMMUNITY ORGANIZATION; SOCIAL PLANNING IN THE PUBLIC SECTOR.

PUBLIC SOCIAL SERVICES

Social services in the United States historically were provided by family, friends, neighbors, and church groups. Prior to the 1900s, this pattern was the dominant pattern in social services delivery. The role of government in planning, funding, or delivering social services was slow in developing. Morris (1979) indicates that social services remained outside government activities until 1936 when the Social Security Administration urged Congress to provide social services to families on relief. Bell (1983) points out that prior to the 1960s, there were few social services. According to her, what few social services existed were “monopolized” by the middle class. These services were provided by the voluntary, nonprofit social welfare agencies that developed during the first half of the 20th century.

The development of public social serv-