Health and Welfare:

Single or Separate Ministries?

Anne Letsebe & Jackie Loffell

Many social service personnel favour separate health and welfare ministries, rather than a combined authority. Anne Letsebe and Jackie Loffell examine central aspects of the debate, and report the views of a number of strategically located social workers.

The Case for a Single Ministry

A single health and welfare system would seem, at face value, to be the obvious choice for South Africa, as medical and welfare practitioners and their allied disciplines have, in recent years, been moving out of their airtight compartments, and have been developing a common vision. Increasingly we share a holistic language in which we speak of the promotion of the physical, emotional and social well-being of a person, families, communities and the nation.

Social workers speaking of the root causes of social problems, and doctors outlining the root causes of disease in South Africa, speak constantly of the same factors - poverty, illiteracy, homelessness, lack of basic facilities, rapid social change and associated stress, etc. Many locate the root causes of these health and welfare problems in our political situation, and look to social justice as a prerequisite for adequate health and welfare.

As a country with scarce human resources we cannot afford, it may be argued, to fragment our services. Under a new government, primary health care should be at the heart of the system, blending skills of social service workers and health workers at every level. The influx of abandoned babies into hospital beds and the AIDS crisis are two examples of areas in which a structured, unified approach would be a great advantage.

The Case against a Single Ministry

In theory, a division of health and welfare functions would cause wastefulness, and a reversion to a less enlightened, falsely dichotomous era. However, the over

whelming view of social workers interviewed in a recent survey is that combining the administration of health and welfare services would not work.

The views of key people in the field of social welfare were canvassed. Some spoke in their personal capacity, while others gave the positions of their organisations. The views presented are those of twenty four people, including representatives of professional associations of social workers, heads of social work departments, directors of national councils, and senior personnel in social welfare and health departments of the 'homelands'. The experiences of the latter were particularly illuminating, because some of them have had the experience of working both under combined health and welfare ministries and under separate ministries. The table below summarises their views on the issues of debate:

Respondents	Views supporting separate ministeries of Health & Welfare		Views supporting a joint ministry of Health & Welfare		Totals	
	No.	%	No.	%		
Professional Associations	3	100	0	0	3	100
University Heads	10	91	1	9	11	"
National Councils	6	100	0	0	6	"
Homeland Minsitries of Health&Welfare	5	100	0	0	5	

Views supporting/opposing a single ministry of health and social welfare

The view of almost all those interviewed is that health and social welfare services should be provided through separate ministries.

Why the choice of separate ministries

Respondents argued that separate ministries would achieve greater impact by focussing on social needs as such and hence rendering more effective social

welfare services. A non-racial ministry of social welfare would focus on the specific problems of social welfare which would be overlooked in a joint ministry. These include problems relating to social and emotional stress in coping with change and transition, and an urgent need for effective social security and social development programmes.

In a separate ministry, social welfare would be able to develop its own identity. In its own right, social welfare would draw on other disciplines, to best serve the needs of the people.

It is interesting to note that in Mozambique, the combination of departments of health and welfare is considered to have been a mistake, and is being reversed. Moreover, the view that health and social welfare should be in separate ministries is not new to South Africa. In 1985, when a proposed social welfare policy was investigated, the social welfare community called for a separate, non-racial ministry of social welfare .

Conflicting values

Differing perceptions of values between medical practitioners and social workers are another factor in the ambivalent relationship between the two professions. In particular, the values of self determination and respect for the integrity of service consumers in the totality of their life situations are a constant sources of conflict.

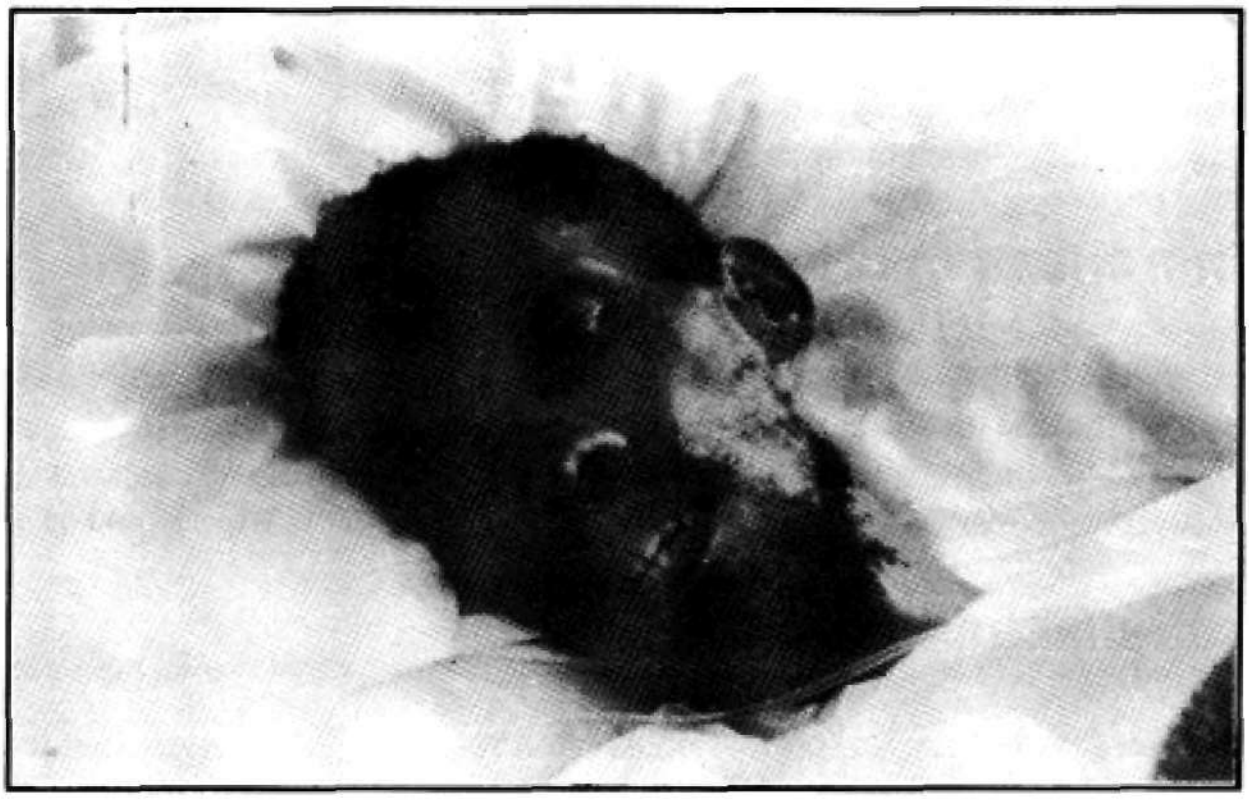
Social workers are trained to operate at the level of the client and arrive at treatment goals with the client. In this process, the primary consideration is empowering the client to make decisions about his or her life with professional help.

Even though the medical profession may be moving towards implementing the principle of empowerment, social workers continue to encounter problems with the practice of physicians. Physicians develop a treatment plan and instruct patients accordingly. While students in both professions are taught about the importance of confidentiality, the experience of some of the respondents is that it is not strictly upheld by physicians. A commonly cited example is the ward round when doctors discuss patients' diagnoses within hearing distance of the rest of the patients in the ward. This affects the privacy of patients.

Discrimination in favour of the medical profession

a)Resource Allocation

Whenever health and social welfare are found together, budgetary allocations are



Physical health issues are given priority over the broader psycho-social issues that affect patients. *Photo: Medico Health Project*

always weighted in favour of medical health. In many instances where savings have had to be made, these are often at the expense of social welfare services. However, when patients are referred to social workers, high expectations are created about what the social workers can do to alleviate their material conditions even where the resources do not exist. In the allocation of office space and transport, some respondents said, priority is given to medical services under joint administrations.

Such discrimination in the allocation of resources is perceived to undermine the effectiveness of social welfare services by limiting their scope and creativity.

b) Promotion and status of staff

According to some respondents, in cases where decisions are to be taken on issues relating to health and social welfare, the practice has invariably been to give more weight to the medical professionals. The experience of social workers working in the 'homelands' shows that where the two professions combine, senior positions are usually held by health care professionals. This affects the morale of social workers and has a direct impact on the quality of service.

Doctors' immediate power over life and death in emergency situations gives them a status and authority rooted in people's anxieties about sickness and death. A particular status is, therefore, attributed to doctors in the wider community. This

allows them to wield an unusual amount of influence over members of other disciplines. The tendency, therefore, is that physical health issues are given priority . This is certainly the case in present Department of National Health and Population Development, although it is headed by a social worker.

Differences in orientation

Interviewees felt that differences in orientation make a single ministry inconceivable. They said that the medical discipline focuses on physical health whereas the social services focus on human relationships. Although these are closely related fields, they involve separate bodies of theory and of expertise.

Multi-disciplinary team work

Social workers and medical professionals often hold very different perspectives on decision making in team work. Whereas social workers are taught the importance of co-operation, physicians are trained to command and they tend to take leadership roles in any multi-disciplinary effort. The consequence is an undermining of team effort. Thus, as one of our respondents says,"In all my twenty three years of working in a team, I have never experienced team work because the doctors always take over regardless".

All the people interviewed identified the need for co-operation between the professions, but preferred a structure of co-operation in which neither profession dominated. One-stop services at which multi-disciplinary teams could be easily accessed by clients were suggested.

Conclusion

The considerations in favour of a single health and welfare system are compelling. The reality is that when government structures bring together people concerned with physical, emotional and social health, those specialising in physical health tend to dominate.

The disadvantages identified by social workers, who are key players in the social welfare field, outweighs the perceived advantages of having health and social welfare together. Their experience suggests that the attainment of the best value from each profession will occur through separate systems. The fact that the responses are based on current experience amplifies the need for intervention

strategies to take heed of the issues raised.

There needs to be a concerted effort at developing training that will produce personnel who understand the relationship between the professions, and the contribution of the various professions to health and social services. The express aim should be to ensure that health and social services will respond fully to both the physical and the psycho-social needs of service consumers.

References

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