Keep Health and Welfare together!

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The author employs a mental health perspective in response to Letsebe and Loffell, and argues in favour of a single unified health and welfare department.

Introduction

The question of the structural relationship between welfare and health is a fundamental one. It affects not only the choice of whether to have a single or two ministries for health and welfare in the post-apartheid government, but also how existing health and welfare organisations define and arrange themselves. It also demarcates present and future levels of contact and co-operation between the two sectors and shapes the perception of both providers and consumers as to the nature of health and welfare.

In their article Letsebe and Loffell present the positions of a number of professional social work organisations, university social work heads, national councils and "homeland" welfare departments on the issue of whether to have one of two ministries for welfare and health. The response is, with one exception, overwhelmingly in favour of separate ministries. The authors and their respondents make a number of telling points as to why health and welfare should be separate. Given this, the task of giving the "other" side is daunting. I feel I may be accused of "not listening to the community" or being "anti-democratic" for raising an argument which, from within the field of welfare itself, seems more or less already agreed upon. These points may be made particularly because I am an outsider to welfare. However the very fact that I am not a social worker, but work in mental health which covers both health and welfare, puts me in a position to add constructively to the debate. In this short response I will show the advantages of a single structure from the mental health perspective (1). I will then briefly deal with some of the more contentious issues raised by Letsebe and Loffell on a more general level.

Mental Health - the Need for a Single Authority

Increasingly mental health is being recognised as not simply the absence of mental illness, but as a state of psychological and cognitive well-being. Physical health is generally seen as a major contributing factor to achieving this. Increasingly too there is recognition that mental health services should include curative, preventive and promotional interventions. Within this framework mental health is neither health nor welfare, but spans across the two. The question remains though whether the two aspects would be best facilitated through integrated or separate departments. I will give three examples of why I think one department would be preferable.

1. A case history in favour of a single ministry

X has a severe mental disturbance. Following a period in an institution he is discharged to "community services". At this point he hypothetically needs (at least) ongoing medication, counselling for himself and family, a disability grant and daycare centre facilities. Within separate health and welfare departments X would almost surely be given medication through the health department and a disability grant through welfare; however the remaining interventions could theoretically be administered by either department. Within a holistic approach to health care counselling and providing services which prevent relapse would certainly be acceptable **health** interventions; at the same time though these tasks are also defined **welfare** areas. A real possibility exists that these "grey" areas could either fall between the two departments and not be given any attention at all, or there could be duplication of services. X may also be given two home visits, one by the department of health to see that he is controlled on the medication given, and one by the department of welfare in order, for example, to fill in a disability grant form.

After this, X may have to go to one place at one time to get his medication and to another place at a different time to get the grant money as the two functions would be unlikely to be synchronised across departments. X would have two sets of records - as a patient within health and as a client within welfare. The information on the patient collected by one department would not necessarily be available to the other and would certainly not "filter" across departments.

Health and welfare functions need to be co-ordinated. *Photo: Medico Health Project.*

At a later stage X's condition may improve and personnel in the Department of Health may decide that he should cease to receive a disability grant. (These decisions are made by medical personnel). This decision would need to be communicated across departments and transferred into the welfare file for implementation. The chances of mistakes being made is substantial.

Within a well run single authority on the other hand a person's treatment programme could be planned within a multi-disciplinary team. Given that resources are scarce, one person, with perhaps supervision from a psychiatrist and a social worker, could combine the community health and welfare functions. All the information on the person could be kept in one file, and provision could be made so that dates and places for receiving grants could be combined with medical treatment.

An argument could be made that with sufficient co-operation between departments the same results could be achieved. In my view such co-ordination would be extremely difficult, if not impossible. This would be especially true where one person was expected to do the work of two separate Departments, with separate guidelines.

2. Defining areas of responsibility

If welfare and health were to fall into separate ministries it would be necessary to define who should be responsible for what tasks. For the purpose of this article, and because this is a likely scenario, let us presume that macro preventive and promotive tasks within mental health would fall under the authority of a department of welfare rather than health. A major problem here would be that in many rural and underserviced areas there is no social worker who has time to spend on mental health, other than perhaps dealing with disability grants (3). What little intervention does occur, is usually done by psychiatric nurses. There are certainly strong arguments to suggest that psychiatric nurses in these areas are in fact the people best placed to carry out these functions. However unless these tasks are in fact defined within the framework of the employing department (that is, health or health and welfare), they may disappear from these underserviced areas altogether. Though it could be possible for a department of welfare to "hire" people from the department of health to do certain welfare tasks, this is less rational than having a single authority planning services - especially when these tasks are not clearly either health or welfare. Moreover where personnel are overworked, it is unlikely that work from another department may be given higher priority than those of ones own department.

3. Planning services

Problems of separate ministries may also arise where policies made in one department have profound effects on the other Department. For example the department of welfare may decide that a policy of selectively discharging patients from psychiatric institutions should be pursued, and that they, as a department, would be prepared to take over much of the responsibility for these discharged people - if they were given sufficient resources to do so. As the department of health would still control the institutions, this policy would have little meaning unless the department of health agreed and discharged the relevant patients. This would mean transferring financial resources from the department of health though, and may leave some people in the department of health without employment. The department of health may resist the change for these practical reasons rather than on the merits of the policy itself. The converse is also possible. The department of health may be ready and prepared to discharge patients, but the department of welfare may feel that this was a mere dumping of patients and responsibility, that the resources which came across from the department of health would not be

sufficient, and may resist again on grounds not related to the merit of the policy.

While it is again possible to see co-operation between departments, the likelihood of success would be advanced if planning took place within a team, and agreed within one department rather than across departments.

Will welfare necessarily be compromised within a single structure?

It cannot be disputed that at present welfare is neglected relative to health services, and that medical personnel dominate welfare personnel. This may not however be reason enough to separate health and welfare. In fact it may be argued that it is necessary and strategic for welfare personnel to engage health structures directly and now.

One of the main reasons that Letsebe and Loffell give for remaining outside of health structures is the fact that health and welfare personnel "work differently" and that welfare workers are dominated in their relationships with doctors. This is indeed true and needs to change. However, this change need not necessarily occur through splitting welfare off from health, but by welfare workers asserting themselves more effectively in joint structures. For example much more power needs to be asserted from within welfare structures so that social workers can also take charge of a multi-disciplinary team rather than the doctor automatically playing this role. Rather than separating off from health structures, social workers have a responsibility to positively influence the way medical personnel operate. By disengaging welfare from health the medical model and the authoritarian nature in which much of medicine in South Africa is practised will flourish. In order to "humanise" the way medical personnel practice their profession; in order to help the medical profession see the social nature of much illness and adapt solutions accordingly; in order that medical personnel learn to listen to what their patients are saying more effectively, it is essential for very close contact with welfare to be maintained. By increasing the gap between health and welfare, health personnel will become more entrenched in their non-welfare oriented approach and patients will become **less** empowered. It is not strategic to empower the population in one aspect of their lives, yet by giving up the fight to influence the medical profession, be in part responsible for their disempowerment in another. Moreover the split is likely to mean that patients\clients themselves will cease to see themselves as whole individuals, but will see their social needs as separate from their bodies.

It is my belief that rather than setting up separate ministries for health and welfare that the kind of autonomy that welfare personnel are seeking should take place through a single ministry, but with Departments **of equal status** for Health and Welfare. This would allow welfare personnel to keep welfare issues in focus, but at the same time plan services together with health personnel.

Conclusion

The fact that welfare has not been getting a fair deal vis-a-vis health in South Africa is clearly reflected in the views of welfare personnel. This view obviously needs to be taken very seriously indeed. However the question is not straight forward when it comes to planning and implementing services where there is overlap. The possibility that interventions may be compromised by this separation should be considered very carefully before decisions are made. Though in this response the example of mental health has been used, I have little doubt that similar problems to those discussed would occur in other aspects as well. Letsebe and Loffell themselves give the examples of AIDS and foster children; physical disability, drug abuse and family abuse are others which come to mind. Also the potential for welfare to influence health personnel and the public positively should not be underestimated and further thought is needed in this regard. Placing welfare on an equal footing with health administratively within a Department of Welfare and Health, with each able to argue for its own budget and way of functioning may be a first step in this process.

Footnotes

1. Before final decisions are made it will be necessary to gauge the views of other groupings outside of welfare. The views of health personnel are as critical to this decision as those involved in welfare.
2. Depending on the resources available the person may not receive any home visits at all.
3. The social worker has no time to promote the fact that grants are available and many people who may be eligible will not receive these grants.

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