COMMENTARY

Doctors and social workers

RUDOLF KLEIN

The Government's latest expenditure plans mark an important change of policy in at least one crucial respect. The balance of spending priorities between the Health Service and the personal social services (PSS) has been shifted decisively in favour of the former. The NHS's budget is planned to increase in the coming financial year, if only modestly; the budget of the local authority PSS is to be cut by 5%.¹ So ends a decade during which expenditure on the PSS has been rising considerably faster than spending on the NHS. In 1968-9 spending on the PSS accounted for only 5.2% of the combined NHS/PSS budget; in 1978-9 the equivalent figure was 15.9%.²

On the face of it this reversal of previous priorities would seem to be perverse. The rise in spending on the PSS reflects various factors; but without doubt one of the main reasons was a conscious decision by successive governments to strengthen community-based services in an attempt to ease the demands on the more expensive hospital sector, in particular by developing improved provision for the elderly. Indeed, the whole concept of joint funding—whereby NHS authorities can transfer money to local authorities for specific projects—assumes that money may be spent in a more cost-effective way in the personal social service sector than in the NHS. The apparent most-favoured-service treatment given to health in the Government's expenditure plans may therefore be illusory to the extent that the cut in PSS spending generates extra demands on doctors and hospitals.

The Government's decision makes some sort of sense, however, if it is seen as part of a more general reaction against, and disillusion with, social work. The social work profession has the dominant role in the personal social services, just as the medical profession has the dominant role in the NHS. And it is clear that ministers share the widespread doubts—frequently expressed by doctors among others—about precisely what the role of social workers is and should be.³ There is a growing debate, not least among social workers themselves, about what their specific, unique contribution is. What they can do which other, less highly trained workers could not do just as well? Why, in other words, do we need any social workers at all?

In exploring this question it is perhaps best to start with the medical profession, for one of the characteristics of social workers is that they appear to have taken doctors as their model in their efforts to turn themselves into a profession. Strictly speaking, the label of "professionals" applied to them is a courtesy title: there is, as yet, no central register of social workers, just as there is no legal monopoly for the exercise of social work skills. So if we are to understand the problems of the social worker's help we should try to imagine the state of the medical profession in the mid-nineteenth century, just before the creation of the General Medical Council. Social workers now, like doctors then, have developed a code of ethics,

emphasising the responsibility of the practitioner to the individual client. Similarly, social workers now, like doctors then, encompass a wide variety of people with very different educational backgrounds, and much the same tasks may be carried out by both qualified and unqualified practitioners. Lastly, there is considerable doubt now about whether the intervention of social workers makes any difference, just as a 100 years ago there was considerable doubt about whether doctors could actually make any contribution towards curing their patients.

Contrasting comparison

Since then doctors have developed the concepts and technologies that justify their interventions. Certainly there appears to be a contrast between the "hard" techniques used by doctors today and the "soft" activities of social workers. What is the social work equivalent of a successful operation for a perforated appendix? What is the social work equivalent of prescribing successfully to reduce the patient's dangerously high blood pressure? The questions are hard to answer in general terms—though there is evidence that specific forms of intervention in specific circumstances can make a difference. When social workers do have success stories—when they arrange a happy adoption, when they help an old person to cope with bereavement, or when they prevent a repeat suicide attempt—proving cause and effect, or showing that it was specific social work skills that made the difference, is extraordinarily difficult.

Part of the problem may be, however, that we are asking the wrong sort of questions: that social workers themselves invite criticism precisely because they have adopted the medical model too closely, with its emphasis on "curing" the individual client or patient. Indeed, the unfortunate thing for social workers may be that they have adopted the medical model just as this is coming increasingly under attack. The result is that they are victims of the same kind of excessive expectations, leading to excessive disillusion, that is apparent in medicine. Consider, for example, the point made by McKeown⁴ that "the determinants of health are largely outside the medical care system"—a conclusion summing up his thesis that the contribution of medicine to the population's health has been grossly overestimated. Precisely the same point could be made about social work. The determinants of social ill health are largely outside the social work system. If juvenile delinquency continues to rise, if dependency in old age becomes an increasing problem, if child battering appears to be becoming more prevalent—and all at a time when the number of social workers has been increasing—then this tells us much about our society and its changing perceptions of undesirable behaviour or emerging needs but little about the effectiveness (or lack of it) of our social services.

One conclusion to be drawn from the argument that doctors' activities make no difference to people's health is that we should stop spending money on the NHS. Indeed, international comparisons suggest that there is no correlation between levels

University of Bath

RUDOLF KLEIN, MA, professor of social policy

of spending and levels of health.² Similarly, it could be argued that since there is no evidence that social workers make any difference to the social well-being of society there is little point in spending more money on them, a conclusion that seems to be implicit in the present Government's economy drive.

Both conclusions show the danger of basing policy on measurable indicators of success to the total neglect of those factors which at present we cannot measure. In the case of medicine, for example, most of the critical conclusions about its lack of impact have been based on mortality statistics. This is because we lack adequate morbidity statistics, let alone measures that would allow us to assess over time the contribution that medicine has made to the population's quality of life, or the extent to which it has relieved suffering, enhanced patients' independence, or improved their mobility. All these difficulties are compounded in the case of social work, where the emphasis anyway is more on the caring than on the curing function. Social workers know perfectly well that the best they can do for most of their clients is to help them to cope with their problems, which may be social, financial, or psychological—rather than “solving” them in a real sense. Indeed, it is precisely this which helps to explain the resentment felt by many social workers at being presented with problems whose causes (in so far as they are remediable at all) lie outside their control. They feel that all too often they are being asked to help people to adjust to circumstances whose remedy is society's collective responsibility. And, to the extent that the personal social services are a dumping ground for those problems that doctors, magistrates, and others cannot tackle, social workers surely have a point.

No open-cheque policy

To argue against a simplistic use of measurable indicators of success, whether in medicine or in social work, is not to argue for an open-cheque policy. In medicine there is ample evidence that drugs and procedures continue to be used even when there is evidence that they are neither effective nor efficient.⁵ It would be astonishing if the same were not true of many methods of social work intervention. In this respect social work differs from medicine chiefly because it is even more difficult to assess impact and to evaluate the effects of intervention, and that the methods for doing so are less well developed. There are in both instances strong grounds for agnosticism, though not for nihilism.

Social workers share one further characteristic—and problem—with the medical profession. In both the PSS and the NHS the direct costs of employing social workers and doctors account for only a modest proportion of the total budget. In the case of the PSS one-eighth of the total expenditure is devoted to “social work” strictly defined,⁶ reflecting the fact that there are only some 15 000 social workers out of a total of 250 000 people employed. The real costs of social workers, as of doctors, is therefore largely measured in terms of the financial implications of the decisions which they make. In short, social workers, like doctors, are gatekeepers. It is they who ration scarce resources by making decisions that help to determine who should get home helps or a place in a residential home. Therein lies their dilemma and the cause of many of the agonising self-doubts to which social workers appear peculiarly prone.

For the basic imperative of social work, as of medicine, is to do the utmost possible for the individual client. It is in every sense a highly personal activity, since the social worker's main tools (lacking medical technology) are his or her own skills in dealing with people. Thus the definition of social work offered by the British Association of Social Workers⁷ is “the purposeful and ethical application of personal skills in interpersonal relationships directed towards enhancing the personal and social functioning of an individual, family, group, or neighbourhood.” Though encased in dreadful committee jargon, the drift of the definition is clear enough: social work is about

doing one's best for people, helping them with their problems, and trying to improve their capacity to cope.

Broker and advocate

But, in practice, much of social work has little to do with practising “interpersonal skills” on clients. Instead, and at least equally important, it is concerned with assessing people's needs, for acting as a broker between different social services, and on occasion playing the part of an advocate for people who do not know their way through the welfare maze. Working in a bureaucracy, the local government services, social workers must first know how to work the machinery to their clients' advantage. Similarly, given the shortage of resources, their ability to say “No” to would-be clients—to classify them according to priorities—may be as important as their ability to help clients.

This tension between competing functions is mirrored in the practice of social work. In practice, social workers spend only a third or less of their time in face-to-face contact with their clients⁸—that is, in conforming to the stereotype of the social worker as an expert in “interpersonal relationships.” Much time is devoted to various aspects of administration; the job of orchestrating the various social agencies—of getting the co-operation of supplementary benefits offices, housing departments, and so on—may be time-consuming. Moreover, much of the work has to be done without adequate administrative support. A recently published national survey of social work practice⁹ suggests that the skills of trained social workers are being wasted for lack of assistance in carrying out chores. Some local authorities do not appear to believe in employing social work assistants, with the result that social workers have to carry out routine jobs such as ferrying clients by car or returning walking aids, which could easily be done by unskilled helpers or volunteers. Indeed, the dominant impression left by this survey is of social workers overwhelmed by a multitude of tasks, ranging from the desperately urgent to the trivial. Nor is this surprising, given that there are only 15 000 social workers, compared with 25 000 GPs.

All this might suggest that much of the criticism of social workers is beside the point. The real question to ask, surely, is not so much whether social workers are effective but whether social work could be organised in such a way as to make them more effective by making more efficient use of their skills. Specifically, we might argue that we do not necessarily need more social workers—but that we do need more secretarial support and more social work assistants and aides, as well as more volunteers, to take on those duties where highly and expensively trained men and women are not needed. For instance, the need for social workers to carry out the caring role of the social services, such as routine visits to the elderly, is not self-evident.

Generic social workers

Equally, we might well ask why social workers have not followed the doctors' example more consistently. The Seebohm Committee¹⁰ conceived the idea of the “generic” social worker: that is, an all-rounder commanding all the skills required, rather than a specialist in child care or in psychiatric social work. This was an admirable concept when applied to the education of social workers, but it has also been applied to the day-to-day working activities of social workers. The assumption is not only that all social workers should be equipped with a basic set of skills and trained to command the same conceptual tool-kit but that they should also function as generalists: that they should perform both the gatekeeping role of the GP and the specialist role of the consultant. It is as though GPs had to be their own surgeons, pathologists, and psychiatrists. This pattern of work may well generate excessive demands on social

workers, in particular on their abilities to develop their skills in a variety of fields; and a different system may be required. For example, some social workers might concentrate on their screening role in assessing needs and acting as brokers between different social agencies, while others might concentrate on developing the special skills needed to work with particular kinds of clients: families suspected of battering babies, delinquent children, the mentally ill, and so on. In other words, social workers may have to overcome their reluctance to be regarded as an elite. They may have to recognise that, like doctors in the NHS, their function is to take crucial decisions and that, accordingly, they will have to become specialists in the skills needed to take the various kinds of decisions and to lead the equivalent of a clinical team.

So there are many reasons for questioning the present organisation and function of social work. Indeed, critical self-inspection appears to be the occupational disease of social workers, and they probably do more soul-searching about their own role than most professions. Furthermore, it is a profession in the process of evolution. Many of the criticisms of social work reflect the inevitable consequences of trying to expand numbers extremely rapidly in the post-Seeborn period. The social workers emerging from the universities and other institutes of higher education are now probably very different from many of those produced 10 or fewer years ago. Then social workers might have been described as people who (to paraphrase Oscar Wilde) knew the values of everything but the price of nothing: dedicated to reforming the world with no sense of economic or organisational realities and thus doomed to disillusion. Now this is no longer the case. For example (to declare my interest), our social work students in my department at the University of Bath are given not only a professional training but, as part of this, also an introduction to the economic and organisational facts of life.

If the Government wishes to edge the social work profession towards change and if it wants the personal social services to be more efficient in their use of resources I can sympathise with its aims. But whether this will be achieved simply by cutting budgets is doubtful. On the contrary, this policy may simply encourage everyone to bury themselves deeper in their entrenched positions and prejudices. The last Labour government thought that it could change medical practice in the NHS by clobbering the doctors. It did not succeed. So the present Conservative government has clearly decided that the best way of keeping the NHS afloat in a difficult period is by maintaining the morale of the key profession. Perhaps there is a lesson in that for the Government's strategy towards the personal social services.

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Community medicine and NHS reorganisation

The Central Committee for Community Medicine met in December before the Government's consultative document, *Patients First*, was published (15 December 1979, p 1605). The specialty's views on this will be co-ordinated at the next meeting on 8 February. The committee is, however, concerned at how arrangements for staff will be affected by any reorganisation and it has sent the following recommendations to secretaries of regional committees:

Protection should be no less favourable than for the 1974 reorganisation.

Disturbance should be minimal—that is, those in single-district areas should retain their present posts.

There should be full consultation with individuals who are affected by restructuring and, where possible, locally assimilated, taking into account personal preference.

Where no posts are available locally arrangements should be made at regional level by reference to a regional committee made up of community physicians.

In the unlikely event of there being no suitable and acceptable posts within the region, then an agreed system of circulation or advertisement of all vacant established posts should be set up. Only those posts which are open to competition should be subject to advisory appointments committees.

Arrangements for the transfer of community

physicians from one post to another should be made without loss of either status or salary.

All community physicians over 50 should be given favourable terms for early retirement and encouraged to undertake locum work following retirement.

Disturbance allowances, protection, etc, must be carefully monitored by the joint negotiating body.

Any additional work undertaken as a result of restructuring should receive adequate financial recompense.

Community physicians or other doctors subject to reorganisation should be treated no less favourably than other professional groups engaged in related duties.

NHS Supply Council

The Government has decided to set up a supply council for the NHS. Announcing this in the House of Commons on 21 December the Secretary of State for Social Services explained that the council's functions would be to evaluate equipment and supplies offered to the NHS, improve the information to health authorities to enable them to make the "best buy," and to help them to co-ordinate the purchasing of common use items. Health

authorities spend over £1000 million a year on supplies and it is estimated that at least £30 million could be saved by co-ordinated purchasing arrangements. The council will have 12 members. It will not carry out purchasing itself but will advise and recommend on purchasing policies. Health authorities will be required to follow these recommendations when they have been endorsed by the Secretary of State.

Review Body's new chairman

Sir Robert Clark is the new chairman of the Review Body on Doctors' and Dentists' Remuneration. Sir Robert is a merchant banker and chairman of Hill Samuel & Company.