

THE SOCIAL DEVELOPMENT APPROACH TO SOCIAL WORK IN HEALTH CARE

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ABSTRACT

Social work in health care delivers essential services to South Africa's vulnerable populations. The social development approach attempts to address inequalities and uplift vulnerable people. An explanatory-sequential mixed methodological study explored the application of the social development approach to social work in health care in the Gauteng Department of Health. The findings indicated that social workers in health care deliver a diverse service in attending to patients' needs and are ideally situated to address and implement the social development approach. However, challenges are experienced in the absence of strategic policies regarding the implementation of the social development approach in health care.

Keywords: *Gauteng Department of Health, health care reform, health care settings, social development approach, social work in health care, transformation*

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INTRODUCTION

The South African context requires a range of responses to address its vulnerable populations' urgent needs. Social work in health care responds to people's diverse and complex needs once they come into contact with any health care setting (Ashcroft, 2014; Auslander, 2001; Browne, 2006; Dhooper, 2012). This interface with health care settings places people in direct contact with social workers regarding disease and its impact, simultaneously allowing them to address other needs. Social work in health care fulfils the imperative role to address any *social determinants of health (SDH)* to enable compliance and adherence with treatment (Bywaters & Ungar, 2013; Moniz, 2010). This implies that social work in health care is valued for counselling and addressing the SDH and this in turn raises two questions: To what extent is the *social development approach (SDA)* applied in health care in South Africa? Does the application of the SDA vary between different types of health care settings or within the Department of Social Development (DSD) (RSA, 1978).

The purpose of this article is to give a brief overview of health care reform in the South African context and call attention to the absence of social work in the country's health care reform processes. Social work in health care and the role and challenges of social workers in health care are discussed. In unpacking the SDA, the challenges in its application and implementation as well as social workers' dissatisfaction with the approach will be explained. The authors also probe the apparent absence of literature on the SDA in health care. The results from all methods employed reinforce the value of social work in health care. Depending on the nature of the health care setting, the study's results suggest that the SDA is primarily applied according to its principles, as outlined in the White Paper on Social Welfare (RSAb, 1997). The findings revealed that there is still an enormous need for clarity on how to address the SDA in health care. A clear absence of governmental strategies with regard to the transformation of social work health care and the implementation of the SDA were indicated. Considering the diversity of health care settings and policies, a comprehensive framework is required for the SDA in health care.

LITERATURE REVIEW

South African health care context

Concurrently with the political transformation of South Africa, important health reforms were mandated. The political restructuring of health care settings was imperative to address inequalities and mandate equity and accessibility to health care facilities in South Africa (Benatar, 1997; Benatar, 2004; Benatar, Sullivan & Brown 2017; Dennill, King & Swanepoel, 2000; Kautzky & Tollman, 2008; Rispel & Moorman, 2010; Venturino, 2013). The White Paper for Social Welfare (RSAb, 1997b) was issued simultaneously with the White Paper for the Transformation of the Health System (RSA, 1997a). As a framework for the health care system, the White Paper for the Transformation of the Health System (RSA, 1997a) identified areas and processes of transformation. These included reorganising the health sector, identifying focus areas for essential health services (e.g. mother and child health), and clarifying the role of medical doctors and other professionals who form part of the health care system. Further health care reform was directed at improving government assistance, emphasising the re-engineering of primary health care, implementing the National Health Insurance (NHI), performance management and quality assurance (Benatar, 1997; Benatar *et al.*, 2017; Bradshaw, 2008; Olver, Schaay, Saunders &

Kruger, 2011; Venturino, 2013). Ruff, Mzimba, Hendrie and Broomberg (2011) and Venturino (2013) maintained that successful health care reform hinged on addressing the country's economic disparities.

The National Development Plan 2030 (National Planning Commission, 2011) outlined the ideals of the primary health care strategy, but also included targets for instituting the NHI, revitalising the health care sector, establishing primary health care service teams and fostering trained health teams throughout South Africa (National Planning Commission, 2011). Heywood (2014) stressed the importance of growing the health care workforce, i.e. medical personnel, such as doctors and nurses, to achieve health care reform. Omotoso and Koch (2018) and Scott, Schaay, Schneider and Sanders (2017) highlighted the need to address the SDH with any health care reform strategy, such as the re-engineering of primary health care. Although Craig, Bejan and Muskat (2013), Donkin, Goldblatt, Allen, Nathanson and Marmot (2017), Marmot (2005) and Moniz (2010) argued that social workers in health care proactively address the SDH, reference is not made to social workers' involvement in primary health care re-engineering; only community health care workers and medical teams receive mention. Omitting the role of social workers in health care reform is reflected in the profession's exclusion from the White Paper for the Transformation of the Health System (RSA, 1997a) and the National Development Plan 2030 (National Planning Commission, 2011).

The National Association of Social Workers (NASW, 2009) and Gregorian (2005) drew attention to the fact that social workers should be considered and included in plans about health care reform as they contribute to the outcomes. In a country as diverse and unequal as South Africa, one would expect that the role of social workers in addressing the population's needs would have been more explicit, given the importance of their role in the nation's transformation and the 2030 agenda for sustainable development to "leave no one behind", according to the United Nations Sustainable Development Group (2016). Unfortunately, acknowledgement and inclusion of the role of social workers is absent in most of South Africa's policies and reforms. This lack of acknowledgement of social work in health care in transformation suggests the possibility of only limited awareness and understanding of the role and contribution of social work in health care. It raises the possibility that health care reform devoid of social work consultation and acknowledgement may be ineffective.

South Africa's health care reform has had some success, such as more clinics, free health care for children below 6 years of age and the subsequent reduction in the infant and mother mortality rate (Bamford, McKerrow, Barron & Aung, 2018; National Department of Health, 2019); success with the treatment of HIV/AIDS (e.g. Odumbe) (Southern African HIV Clinicians Society, 2014), and a related decline in HIV-related infections (Avert.org, 2020).

SOCIAL WORK IN HEALTH CARE

A brief review of health care reform in South Africa evinces the absence of social work in health care. A possible reason is that social work is generally considered part of welfare and DSD, but not health. Backwith and Mantle (2009), Craig *et al.*, (2013), Marmot (2005), Moniz (2010) and Rine (2016) have argued the importance of social work in health care in addressing the SDH and the common agenda of social justice. Therefore, as indicated by NASW (2009) and Gregorian (2005), with any health care reform it is paramount to consider the role of social work and ensure proper consultation with representatives from the profession. Historically, the role of social work has been shaped by demands arising from the health setting and health care policies, which always responded to the demands of multidisciplinary teams (MDTs), but usually to the exclusion of social workers in the consultation process (Auslander, 2001; Borst, 2010; Dhooper, 2012; Ruth & Marshall, 2017). The exclusion of social work in health sector reform and a lack of consultation are glaringly obvious. This is even the case in welfare, especially in terms of the SDA.

History of social work in health care

The history of social work practice and social work in health care has been well described and recorded in the literature. Auslander (2001), Borst (2010), Dhooper (2012), Ruth and Marshall (2017), Segal,

Gerdes and Steiner (2018) and Skidmore, Thackeray and Farley (1994) have given accounts of the establishment of social work in health care as well as the diverse application of this profession in health care, albeit shaped by the demands of the MDTs and charity work. Internationally and in South Africa, social work in health care started out as charitable or voluntary work (Carbonatto, 2019; Meyerowitz, 1988). Social work in health care in South Africa, however, had to contend with segregation in service provision until the early 1990s in line with country's political development. From this point onwards, social work in health care transformed into a specialist field encompassing health promotion and prevention as well as a range of psychosocial strategies to aid patients in various ways (Carbonatto, 2019; SACSSP, 2008).

Role of social work in health care

Social work in health care plays an essential role in counselling people affected by disease, its impact and losses. Social work also addresses a wide range of social issues, challenges and needs which patients and their families may face. When a patient enters a health care setting because of disease or loss, other psychosocial and socioeconomic needs tend to surface or become more pronounced. Even though the mandate of the social worker in a health care setting is focused on counselling to sustain emotional and physical wellbeing and address the impact of disease, attending to the SDH (i.e. discharge planning, addressing compliance and other social issues) may be more important. Social workers in health care are ideally positioned to detect and address the SDH early on in the process.

Therefore, social work in health care may be viewed as comprehensive and holistic, and inclusive of a wide range of services that are not limited to biopsychosocial assessment, therapeutic interventions, discharge planning and care, education, brokering and mediations (Auslander, 2001; AASW, 2016a; AASW 2016b; Bentley, 2002; Browne, 2006; Carbonatto, 2019; Davis, Milosevic, Baldry & Walsh, 2004; Dhooper, 2012; Gehlert, 2006; Ruth & Marshall, 2017; Segal *et al.*, 2018).

Globally and in the South African context, the role of social work in health care has been of great value and importance because of its unique position in the health sector. Browne (2006) and Segal *et al.*, (2018) indicated that social work is a crucial part of the delivery of optimal and effective health care services. Facets of social work in health care include helping patients deal with the impact of disease or loss, while also ensuring compliance and the health and wellbeing of patients and their families.

SOCIAL DEVELOPMENT APPROACH (SDA)

In 1997 in South Africa, the SDA was introduced in response to the need to alleviate poverty and uplift vulnerable populations. Unfortunately, the implementation of the SDA is complex and ambiguous, as it is a difficult concept to define (Midgley, 2010; Midgley 2014; Payne, 2014). Kaseke (2015) stated that social workers need to be clear about the meaning and implementation of the SDA when repositioning themselves to attend to patients.

The mandate and commitment to the SDA by signatories of the United Nations (UN) had a remarkable history during the 1960s and 1970s, which were declared the decades for social development (Noyoo, 2015). Noyoo (2015) and Patel (2015) identified four major UN initiatives that supported the global implementation of the SDA: the International Conference of Ministers Responsible for Social Welfare in 1968, the Brundtland Commission on environment and development for establishing sustainable practices in 1987, the World Summit for Social Development held in Copenhagen from 6–12 March 1995, and the establishment of the Millennium Developmental Goals (MDG) in 2005 (later replaced by the Sustainable Development Goals (SDG) in 2016). Many authors, including Gray (2014), Homfeldt and Reutlinger (2008), Nicholas (2014) and Patel (2015) cite the Copenhagen World Summit for Social Development as instrumental in creating a unified vision for the implementation of the SDA. In line with this summit's mandate, South Africa developed the White Paper for Social Welfare (RSA, 1997b), which addresses the implementation of the SDA and introduces the transformation of social welfare services (Nicholas, 2014; Noyoo, 2015; Patel, 2015). This White Paper empowered social workers to enforce the

developmental agenda and community work as the dominant mode of intervention and emphasised welfare pluralism, partnerships and collaborations (Gray & Lombard 2008; Midgley, 2003; Patel, 2015).

Various authors have defined the SDA in different ways, with Payne (2014) arguing that defining the SDA is a controversial issue. Midgley defined the SDA as “a process of planned social change designed to promote the wellbeing of the population as a whole within the context of a dynamic multifaceted development process” (Midgley, 2014:13). Midgley (2010) stated that the SDA links interdisciplinary fields and policy interventions, and that it is this nexus of various complementary fields that makes defining the SDA problematic. Elliot (2012) indicated that the SDA should be considered a progressive model of social work with the specific purpose of ensuring social justice and the empowerment of the vulnerable. Both Noyoo (2015) and McKendrick (2001) maintained that the SDA is associated mainly with economic development, assuming that it will alleviate poverty and unemployment. Midgley (2014) indicated the need for a comprehensive macro perspective to influence dynamic changes in integrating social interventions and economic development. Noyoo (2015) argued further that transformation and social change require capabilities, assets, empowerment, strengths and social capital. In essence, the SDA alleviates poverty, reinforces social and economic wellbeing, and encourages self-determination by involving non-state stakeholders, social investment strategies and diversification of social welfare services (Homfeldt & Reutlinger, 2008; McKendrick, 2001; Patel, 2015).

The unifying factors of the SDA are fundamental tenets of the White Paper for Social Welfare (RSA, 1997b) and are summarised as equality, human rights (social justice and dignity for all), welfare pluralism, democracy, economic strategies, partnership, and collaboration (Gray & Lombard 2008; Jones & Truell, 2012; Midgley, 2003; Patel, 2015; Truell & Jones, 2012). The SDA may be viewed as the umbrella concept that combines both social welfare interventions and economic empowerment strategies. While social investment or economic strategies may incorporate capital investments needed to aid others (Midgley, 2014; Patel, 2015), democracy and participation entail proactive attempts at inclusion (Patel, 2015; Truell & Jones, 2012). Partnerships and collaborations, welfare pluralism, voluntarism and enabling policies, a non-governmental and non-profit organisational (NPO) model, balancing government and NPO roles, and innovations are of the utmost importance to uplift others (Patel, 2015). Importantly, attempts should be made to close the macro and micro divide with regard to service delivery (Patel, 2015). This is the importance of community work practices where sustainable projects need to be enabled.

As a direct response to the social development mandate, the formulation of developmental social work was instituted. This form of social work draws heavily on comprehensive community development while acknowledging political and economic factors (Gray, 2014). With this in mind, Gray (2014) indicated that developmental social work should consider the economics of welfare and social security of communities. By no means does this mean neglecting the valuable therapeutic role of social work, but it does highlight that social workers need to become change-oriented and embrace the agenda of poverty eradication and prevention, community development and cultivating strengths through active community practices (Gray, 2014; Kaseke, 2015; Masuka, 2015; Nicholas, 2014). Therefore, developmental social work is holistic as it draws heavily on anti-discriminatory practices that influence social and economic wellbeing, which in turn enhances social care, social control and social change (Lombard & Wairirie, 2010; Masuka, 2015). In essence, developmental social work has its foundation firmly based on social work professional values and ethics, in addition to demanding community practice and utilising effective economic strategies. Some authors addressed social workers' distress in implementing the SDA and developmental social work. The primary reasons revolve around confusion about the SDA, social workers' uncertainty regarding economic strategies, and a general lack of awareness and knowledge of the capabilities required for social workers to address economic issues (Dlangamandla, 2010; Gray & Lombard, 2008; Hochfeld, Selipsky, Mupedziswa & Chitereka, 2009; Hölscher, 2008; Kurevakwesu, 2017).

In summary, the SDA is a progressive approach to the dynamic interplay between various disciplinary fields and socio-economic development and health care, applying a broad macro approach to address poverty and uplift people. Social work has been acknowledged as an instrumental player in this process.

METHODOLOGY

An explanatory-sequential mixed methodology research design was used to holistically explore, describe and explain the application of the SDA to social work in health care settings within the Gauteng Department of Health (GDH). Mixed methodologies are used where both quantitative and qualitative approaches are required in one study to comprehensively explore the same phenomenon (Creswell, 2018; Johnson, 2004; Leech & Onwuegbuzie, 2009; Morgan, 2007; Morse & Niehaus, 2009). This mixed method strategy combined a survey research design by using a questionnaire (quantitative approach) and an interpretative phenomenological design comprising semi-structured interviews and two focus group discussions (qualitative approach).

The findings were triangulated within a pragmatic framework. Pragmatism is the blending of methods, theories and philosophies in answering the research objectives in a comprehensive, creative and relative manner that encourages inter-subjectivity and a clearer understanding of the phenomenon (Bryant & Charmaz, 2010; Creswell, 2018; Margolis, 2007; Rescher, 2012; Shah & Al-Bargi, 2013). As the methodological framework, pragmatism allowed for fluidity between methods and approaches, and encouraged exploration of the phenomenon from different points of view, enabling practical and realistic solutions as well as functional efficacy (Barnes, 2012; Bryant and Charmaz, 2010; Creswell, 2018; James, 2002; Rescher, 2012).

A cross-sectional survey research design enabled the measurement of the phenomenon during a specified time to reflect on the current views, and attitudes towards the SDA to social work in health care. Forty-five surveys were completed and the data were organised and analysed via descriptive and inferential statistics using SPSS (Statistical Package for the Social Sciences) software.

The qualitative approaches utilised interpretive phenomenological research design to acquire a broad understanding and intersubjective exploration of the lived experiences of how others made sense of their worlds (Creswell, 2013; Creswell, 2018; Eatough & Smith, 2008; Hesse-Biber & Leavy, 2011; Noon, 2018; Pietkiewicz & Smith, 2014; Reiners, 2012). Semi-structured interviews were conducted with ten participants and two key informants. Two focus groups of three and four participants, respectively, were facilitated. Interpretive phenomenological analysis was used to analyse the data (Pietkiewicz & Smith, 2014; Smith, Flowers & Larkin, 2009). The themes were identified according to four categories: the nature of social services in health care settings, the SDA, governmental strategies, and the framework for the SDA. Ethical permission was received from both the Human Research Ethics Committee of the University of the Witwatersrand and the five regions of the GDH. However, there was a two-year delay in obtaining ethical permission from the GDH. Furthermore, the response rate from the social workers employed in the GDH was disappointing and very slow.

FINDINGS

Profile of the respondents and participants

Of the 45 respondents who completed the survey, 78% (n=35) had 4–20 years experience in their current health care setting and were ideally qualified to take part. Only 12% had less than four years experience in a health care setting. All hospital settings were represented in the survey with 75.6% (n=34) being in tertiary health care, 11.1% (n=5) in secondary health care, 8.9% (n=4) in clinics, 2.2% (n=1) in specialist settings and 2.2% (n=1) in rehabilitation settings.

Ten participants and two key informants participated in the interviews and were predominantly from tertiary health care settings, with only one participant from a secondary health care setting. One key informant represented social work at a provincial level and another was employed at a regional level. Apart from one participant, all other participants and key informants had more than five years' experience

in health care. Two participants had 21 and 25 years experience in health care, respectively. Although not all health care settings were represented, the participants with extensive experience and the key informants were sufficiently knowledgeable about the different health care settings.

Participants in both focus groups had a minimum of seven years experience in a health care setting. Both groups were represented by participants in either tertiary or district health care settings. The population for this part of the study had appropriate levels of experience and all health care settings were represented.

RESULTS FROM THE QUANTITATIVE STUDY

The survey research design revealed that therapy or counselling was the most important service to be offered, with 51.1% (23 respondents) working in health care settings in the GDH. This is in line with the unique clinical or therapeutic roles as presented in the literature. Varied responses were received regarding macro strategies as respondents found it difficult to distinguish between micro, meso and macro strategies. Macro strategies that were correctly identified and employed were education and awareness programmes as outlined in the health awareness calendar.

With respect to respondents' understanding of the SDA, 88.9% acknowledged its application in health care. However, 44 respondents (97.8%) indicated an absence of governmental SDA strategies for health care. In describing general SDA services offered in health care, the respondents reported grants (n=6), family preservation (n=1), programmes for sustainable livelihoods (n=4), provision of food (n=1), access to free health care (n=2), free education (n=2), poverty alleviation (n=2), partnerships and projects (n=1). Respondents also identified their own SDA strategies that they offered to patients: empowerment of patients (n=3), poverty alleviation (n=1), advocacy (n=2), workshops and education (n=3), screening and referring for grants (n=5), placements (n=6), child protection (n=1), registering of births (n=1), encouraging people to look for opportunities (n=1), methods of social work (n=1), problem identification (n=1), crisis intervention and trauma counselling (n=1), focusing on patients' strengths (n=1) and fostering self-sufficiency (n=1). Based on these responses, the role of social work, including child protection, applying of social work methods, problem identification and counselling, was considered part of the SDA. In addition, 35.6% of respondents (n=16) indicated that ensuring social justice was a core function that they associated with the application of the SDA. It should be noted that some of the indicators mentioned are associated with general programmes in the country and do not necessarily pertain to the SDA. This observation is either suggestive of the challenge of aligning social work roles with the SDA, or it indicates that social work in health care is social development-oriented.

The respondents indicated that there is a relationship between the social work role and the SDA, recording a standard deviation of .823 and a Pearson correlation coefficient of .481. The respondents also identified a relationship between successful role fulfilment and knowledge about the SDA, producing a Pearson correlation coefficient of .535. Despite these findings, most respondents indicated a need for training on the SDA and other courses, and expressed a desire for an SDA framework for health care. Their suggestions for this framework included addressing issues around housing, social wellbeing, financial and physical resources, gender-based violence, HIV/AIDS, empowerment of communities, persons with disabilities, early childhood development, substance abuse, labour market programmes, youth programmes, inclusion of all groups, rights-based, self-determination, prevention and early intervention services, education, employment, and socio-economic status. These suggestions indicate the need for the practical resolution of societal issues facing patients, which is currently lacking in the integrated service delivery model.

RESULTS FROM THE QUALITATIVE STUDY

Semi-structured interviews

As with the surveys, all ten participants and two key informants emphasised the importance of the counselling role of social work. Community work strategies in which social workers were involved were

education and community awareness. Stakeholder involvement and multisectoral collaborations were identified as crucial to service delivery. They also identified their role in relation to MDTs.

Participants were able to identify the core elements of the SDA; they acknowledged its principles and its aim to uplift vulnerable people and offer social justice. Child protection was emphasised as the enactment of social justice and incorporated into the SDA's mandate. The quotes that follow reveal, firstly, an explanation of SDA, and secondly, the complexity of defining the SDA:

Ja, so I, I look at the word social development. I assume it is about bringing about change in terms of people's social environments. So, I am thinking about environments around education and housing and living conditions and poverty – so economics. So, I think it is about bringing about change in the way that people experience their worlds. That will be how I will summarise it. (Participant 1)

I was a little bit unsure because a lot that I heard is about the developmental approach and about the intervention strategies but then I realised it's a lot of what underpins social work practice. And so it's empowerment and having to facilitate by doing, about self-determination, about quality of life. a process of transformation. It's a macro issue that, actually, transformation is positive about their lives. (Participant 2)

The SDA is applied to social work in health care primarily through the principles of empowerment, social justice, advocacy, referral to communities and liaison with stakeholders. The implementation of the SDA has brought with it challenges for social workers in health care. These challenges were identified as the removal of designated powers, referrals to the DSD that remain unanswered for long periods, and failure to consult social workers in health care about matters that affect them. Participants pointed out that the SDA embraces self-determination and equality, but that this is not always implemented. A specific example is the exclusion of non-South Africans from accessing non-emergency public health care. In addition, implementing the Mental Health Care Act does not permit patients to exercise self-determination once they are admitted. Participants mentioned contradictions and various policies that address challenges differently in health care. An example is the home-visit policies in which social workers are mandated to perform home visits as part of discharge planning with the aid of a nurse. However, the policy for nurses does not permit them to accompany patients or social workers. Consequently, patients are not discharged when required.

Participants indicated an absence of governmental strategies for the SDA, but standard operating procedures (SOPs) were identified to regulate social work practice in health care. While these SOPs are seen as helpful, they also affect social workers negatively if they are not consulted or not informed of the SOP in a timely manner. Borst (2010), Gregorian (2005) and the World Health Organization's Technical Brief (2008) all stressed the importance of proper consultation, especially where transformation occurs. This makes changes more manageable.

Focus group discussions

The focus groups emphasised the core functions and competencies of social work in health care. They also mentioned the challenges in offering community work, especially in tertiary settings. The participants identified the limitations regarding the implementation of community work in health care settings. The application of the SDA in their roles and tasks occurs according to its principles. Community work was more readily offered by social workers in primary health care settings than by those in secondary and tertiary health care settings. Both focus groups highlighted the value and pivotal role of social work, but also the devaluing of professional standards because of time constraints, resource restrictions, staff shortages and heavy workloads as a result of the quantitative standards employed by the GDH. Participants were hopeful that the value of the social work profession would be recognised, but expressed a need for specialisation of social work in health care. In addition, they emphasised that the position of social work needs to be reframed from a secondary or support role to that of equal standing with the rest of the multi-disciplinary teams, as expressed by one of the participants:

We are fit to work in health, but when we look at the treatment we receive as compared to other professionals, the treatment is not equal. That is my problem. We are not treated equal to OTs [occupational therapists] to psychologists; but we are professionals.

A further aspect that was raised concerning the role and impact of the SDA was the removal of designated powers. According to the participants, all their statutory powers have been removed and they are entirely dependent on the DSD for assistance in attending promptly to referrals. One participant had this to say:

Here I am in a hospital; I do not have the power to proceed and act and cannot move forward because I am not designated. ... so what qualifies one? ... Is it just because I am there [DSD]? What is so special about someone being designated with statutory powers without any special training?

Throughout the discussions, the fundamentals of empowerment, social justice and advocacy appeared to embody the roles of social work in health care, the manner of application of the SDA and relevance to the social determinants of health (SDH). Challenges with the implementation of the SDA in health care in more practical terms are associated with the type of health care setting and its mandate. The DSD is perceived as the designated owner, with programmes offered by the DSD deemed more applicable to the SDA.

There are numerous policies in health that are not always applicable to social work, but are devoid of any evidence of consultation and imposed on social workers by non-social workers. Possible threats to the social work profession lie in others' attempts to perform the function of a social worker, the performance management and development system (PMDS) and the occupational-specific dispensation (OSD). These threats undermine the social work profession. The suggested ideals for the framework would require an extensive overhaul of how current communication, consultation and implementation practices take place in the GDH. Linked to this is the expectation that social work in academia will be the driving force for change.

DISCUSSION

Data from all phases revealed the varied and extensive nature of social work practice in health care settings and the diversity of settings in which social work services need to be offered. Social work services were recognised as unique and of a specialist nature, as demonstrated by Borst (2010), Browne (2006), Dhooper (2012) and Segal *et al.*, (2018).

The survey indicated that 51.1% of respondents felt that clinical practice, therapy or counselling is the most important service. This was confirmed by interviews and focus group discussions. In addition, the focus groups identified empowerment, support and education as important roles fulfilled daily by social workers in health care. This focal role of empowerment has been well described by Doostgharin (2010) as enhancing patient wellbeing. Service delivery of social work in health care is diverse and versatile in meeting patients' needs. These roles of social work are echoed by AASW (2016a, 2016b), Ashcroft (2014), Ashcroft and Van Katwyk (2016), Borst (2010) and NASW (2009). Winnett, Furman, Epps and Lamphear (2019) drew attention to the social work profession's continued commitment to the empowerment of vulnerable people.

The semi-structured interviews and focus group discussions highlighted how the counselling role of social workers was neglected as a result of heavy workloads, staff shortages and the emphasis on discharge planning. Cleak and Turczynsky (2014) and Doostgharin (2010) stated that discharge planning and seeking placements are time-consuming, and preoccupation with resolving practical needs came at the expense of social workers' counselling role. However, resolving discharge planning issues are part of resolving the SDH and also fulfil the mandate of the SDA.

The perceived position of social workers in MDT requires extensive review. While being a member of an MDT contributed to the unique role of social work in health care, it also created numerous challenges. This was reported by Borst (2010), Browne (2006) and Dhooper (2012) and was confirmed in this

research study. Given the hierarchies prevalent in the MDT, there is a perception that social workers are not really counsellors, but are ‘exit’ members due to their role in discharge planning; they are regarded as support staff that fulfil a secondary role. This designation of support or secondary role negatively affects the perceived value of social workers in health care settings. Segal *et al.*, (2018) and Skidmore *et al.*, (1994) acknowledged that there should be reciprocal relationships between social workers and the MDT. The World Health Organization (2014) has actively declared that a workforce is comprised of all role players involved in offering holistic health care. The members of the MDT fulfil diverse roles in offering optimal and holistic service delivery for ensuring patients’ wellbeing. The social work profession in health care appears to have limited authority and ownership of the core fundamentals of their role. This was especially apparent in policy or SOP changes that impacted on the social work role. In all phases of the research study, the respondents and participants felt powerless, unappreciated and undervalued. Borst (2010) and Gregorian (2005) emphasised the importance of appropriate consultation with social workers and pointed out that where this does not occur, social workers feel marginalised. The survey confirmed that when social workers were consulted and valued, and supervisors and managers advocated on their behalf, they were content with their role.

The macro strategies in health care identified by respondents and participants included health talks, awareness and outreach programmes according to the health awareness calendar, referral to community resources, and liaison with stakeholders. These were duly noted as vital to holistic service delivery for patients and may be linked to the principles of welfare pluralism. The focus groups, in particular, pointed out that social workers based at clinics or community hospitals, i.e. primary health care settings, could facilitate proper community practice.

The SDA identifies community work and investment strategies as imperative for effective community upliftment. This is in line with Beytell’s (2002) findings on community work strategies and are a challenge in secondary and tertiary settings. The participants remarked on their unique contribution towards awareness campaigns, psychoeducation, referral and liaison with stakeholders such as the South African Social Security Agency, the DSD, the South African Police Service and the Department of Education to ensure service delivery. This is in line with the tenet of welfare pluralism in the SDA (Gray, 2014; Lombard, 2008; Midgley, 2014; Noyoo, 2015; Patel 2015). Gray (2014), Midgley (2014) and Patel (2015) elaborated that involvement with more than one stakeholder is necessary for effective service delivery, social upliftment and enhancing a multimodal approach to the SDA. Therefore, the role of the social worker is key to connecting with appropriate stakeholders. Awareness campaigns are also informed by community education strategies of community work, as proposed by Weyers (2011). Stakeholder involvement and multisectoral collaborations have been widely recognised as key to offering effective and comprehensive services to communities. These strategies should be regarded as valuable manifestations of the SDA, especially considering the challenges that secondary and tertiary health care settings experience in implementing community development. Participants revealed that as the owner of the SDA, the DSD and its social workers are ideally positioned to implement community development strategies and programmes.

Even though the SDA is clearly implemented by way of its principles, several challenges were identified in all phases of the study. As a concept, the SDA was considered confusing, and its application remains a challenge. With respect to the principle of self-determination, deinstitutionalisation is encouraged, which appears to be inconsistent with the needs of patients with mental health challenges who require institutionalisation for their protection and wellbeing. A further contradiction, as highlighted by participants, relates to patients’ rights to practice their own beliefs according to their religion or culture; the legislation does not permit this when a patient is admitted according to the Mental Health Care Act. While the SDA emphasises inclusion, this does not apply to the medical treatment of non-South Africans, as the current legislation prevents more than emergency treatment in public health care.

Minimising or removing the designated powers of social workers in health care settings through the application of the SDA contravenes the Social Service Professions Bill (RSA, 1978) and the general outcomes

of the Bachelor of Social Work degree. The removal of these powers requires further investigation, but what is clear is that it diminishes the perceived competence and value of the social worker in health care. This is a gross violation of the core fundamentals bestowed upon all qualified social workers.

All participants indicated that the framework should include practical solutions to aid patients and their families. Currently the implementation of the SDA takes place in terms of the SDA principles. These principles are not unfamiliar to the social work profession, but further practical plans, steps or guidance are needed. Gray (2014), Lombard (2008), Midgley (2003, 2010, 2014), Noyoo (2015) and Patel (2015) referenced the need for investment strategies and comprehensive multimodal approaches to the development of communities. As part of the framework, participants suggested that communication and consultation with social workers should be mandatory. Linked to this is the requirement that a bottom-up approach should be adopted, which will enhance ownership by the social work profession and influence how interventions occur. This will also allow for social workers to generate their own roles. Leadership, i.e. supervisors and management, should play an instrumental role, but should also be open to directives from social workers.

CONCLUSIONS

Social work is a diverse yet essential component of health care and applies principles of empowerment, advocacy and social justice with patients. Therefore, the SDA, in ensuring social justice to all, is intrinsically connected with social work. This research study provided a fundamental understanding of the application of the SDA to social work in health care.

Despite its emphasis on counselling, this facet of social work is often neglected because of staff shortages, an output-driven focus, heavy workloads and greater demands on discharge planning. Social workers are involved, to a lesser extent, in community work. In tertiary and secondary institutions, this is limited to awareness and educational strategies by using the health awareness calendar. Counselling or therapeutic services that focus on enforcing social justice, empowering patients, stakeholder liaison and multisectoral collaboration are crucial to effective social work services in health care. Similarly, referrals and multisectoral collaborations are essential to addressing patients' needs using the SDA framework.

Even though the participants and respondents expressed hope for the future of the social work profession, emphasising its value and the unique role it fulfils, major concerns emerged from the study. Participants identified current perceptions of social work in MDTs, the occupational-specific dispensation, and the performance management and development system as distinct processes that have the effect of diminishing the role of social work in health care. In particular, the PMDS has diminished the role of social work to that of auxiliary workers, giving rise to the perceived motivation that it is preferable to employ auxiliary workers rather than social workers. It is recommended that these concerns be specifically addressed by the GDH and the South African Council for Social Service Professionals (SACSSP, 2008).

Addressing the value and perceptions of social work in health care requires effort on the part of the GDH, which needs to carefully consider staff shortages and the workload allocated to social workers. It needs to recognise that social workers in health care address patients' needs and concerns, perhaps to a far greater extent than their counterparts in the DSD do. Employing more social workers in health care will provide greater coverage of and attendance to the needs of South Africa's vulnerable populations, which will successfully implement the mandate of the SDA.

Social workers could well be the catalyst for the successful implementation of the SDA, considering that other members of the MDT are not as well informed about the approach. Furthermore, even though social workers in health care have limited opportunities to implement community work, the principles of the SDA are central to ensuring wellbeing, social justice and attending to the needs of the country's most vulnerable people.

The participants indicated that the SDA is diverse and confusing to grasp, suggesting a need for further training. Furthermore, the application of the SDA through its principles should be acceptable measures. It is recommended that the GDH institute an intensive training programme for the SDA that customises the SDA for different types of health care settings. Linked to this is the need for a comprehensive

framework to offer effective guidance to social workers on each level. While this framework should include the principles of the SDA, it should also provide practical steps to enhance multisectoral collaboration and social investment strategies. The strategies contained in this framework should embrace transformation.

The biggest aspect of establishing this framework is altering the view that the DSD is the owner of the SDA. The fact that the DSD removed powers from social workers in health care does not help its cause. Despite this misconception, social workers in health care remain the catalysts for enacting the SDA in hospital settings. This needs further exploration as it should be possible to apply the SDA to the entire country.

It was noted that social workers employed in health care settings have difficulty in delivering services related to statutory work. This necessitates a strong dependence on DSD for statutory service delivery. In these cases, the statutory powers should not be removed altogether, but perhaps altered to accommodate the working environment, with the DSD refraining from directing the roles of social workers in health care. The GDH should strengthen its social work team, currently under the Special Programmes Directorate, to direct social work roles in health care.

This study attempted to investigate the question of how social work in health care implements the SDA. Despite their confusion, social workers in health care have made proactive attempts to implement appropriate SDA strategies, while also addressing patients' fundamental needs. The study concluded that social workers in health care are ideally placed to resolve issues around the social determinants of health, while also addressing and fulfilling the mandate of the social development approach.

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