

Sociomedical Development Work at a Social Welfare Office In a Metropolitan Area

A Preliminary Report

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The physicians of the Sociomedical Clinic at Malmö General Hospital each serve ten hours a week at the local social welfare offices in Malmö. The better part of the time is devoted to thorough examination and evaluation with a view to socio-medical rehabilitation of long-term clients of the social welfare offices. The article presents a part of a survey concerning 101 patients who have received such socio-medical rehabilitation. The survey is based on material in records from hospitals, the social welfare offices (concerning social welfare, alcoholism and child welfare), the county regional employment board and the state social insurance office. The material has been structured according to a questionnaire and then statistically arranged. The article gives a picture of the patients' social and medical backgrounds as well as their status at the commencement of rehabilitation. The article furthermore discusses the cooperation between the open social and medical care on the basis of data obtained in the survey.

The Department of Social and Preventive Medicine at the University of Lund is located partly at the Lund Hospital, and partly at the Malmö General Hospital. In Malmö, activities are closely connected with clinical work and the department functions, amongst other things, as a referral body for patients with complex problems of long standing, both medical and social in character. To this end effective cooperation has been established with the General Insurance Fund, Labour Care Service,

County Labour Board and the Social Services Administration.

In the 1970s the Social Services Administration in Malmö entered a period of reorganisation, when the chief medical officer of the Sociomedical Clinic in Malmö shared in the planning activities. Open social welfare in Malmö now operates on the so-called family principle, meaning that one social worker attends to all matters concerning the same family. In connection with this reorganization of activities, sociomedical work was begun in the local welfare offices.

Malmö has six local welfare offices with a population catchment of about 50 000 inhabitants each. In addition there is a welfare office for persons lacking housing accommodation. In each office a physician from the sociomedical clinic is on duty 10 hours a

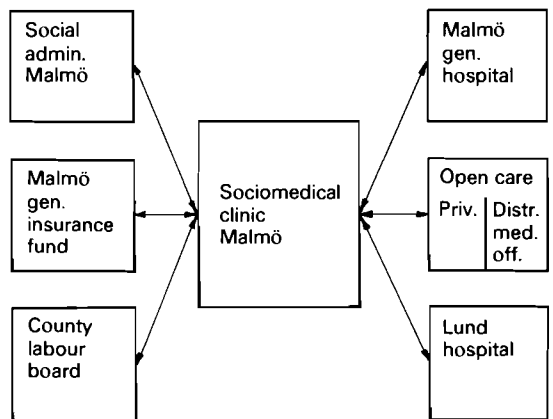


Fig. 1. The integrative position of the Sociomedical Clinic.

week. The better part of the time is devoted to thorough examination and evaluation preparatory to long-term sociomedical rehabilitation. About half of the time is devoted to patients in need and the other half to discussions with social workers and patients on how to plan and follow up the rehabilitation. For the rest, the physicians are busy at the sociomedical clinic, in clinical work as well as research and tuition. Our experience shows this to be a "prescription" against the tendency to isolation that, by the way, always lies in wait for a physician who serves the social administration full-time. This structure also gives the patients substantially increased opportunities to utilize other rehabilitation services.

At the 4th Social Welfare office under the Social Services Administration in Malmö, sociomedical activities were begun in 1970, or a couple of years later than at the other offices. The social workers have referred back all cases where they have considered a contribution from a sociomedical consulting physician necessary. Though their burden of work has been very heavy in the last few years, above all because of increasing duties in social relief activities, the social workers have paid a good deal of attention to sociomedical cases, and extensive social investigations have been carried out. The case workers have found it expedient to analyse the patients' social and medical problems more closely in cooperation with the sociomedical consulting physician, in order to obtain a clearer picture of the sociomedical problems as a whole and so be able to plan their measures accordingly. In our opinion those sociomedical patients give us a very concrete and immediate idea of the continuous fluctuations within society, and therefore it is not advisable to become too firmly attached to routine activities regarding sociomedical rehabilitation. Thus, for instance, the problems of the new suburban areas in metropolitan regions have been very much to the fore in the sociomedical field during the past decade. Consequently, a continuous evaluation of the activities is of great importance.

METHOD

We present here only very preliminary results from a study of sociomedical cases dealt with at the 4th Welfare Office in 1970. We have tried to chart the social and medical background factors as well as facts that have emerged in the course of the investigation, and we have also made attempts to evaluate the results of the sociomedical rehabilitation. The study is based on hospital *diaries* from the sociomedical

Table I. *Age distribution among the sociomedical cases at the 4th Social Welfare Office, Malmö in 1970*

10-19 years	7
20-29 years	26
30-39 years	22
40-49 years	23
50-59 years	12
60-69 years	6
70-79 years	4
80-89 years	1
Total	101

cal and other departments at Malmö General Hospital, the *welfare office's* case reports concerning social relief as well as children's care and temperance care, and on the proceedings of the County Labour Board and the Insurance Fund. The 4th Social Welfare Office covers two distinct geographical areas: Limhamn, which has older settlements and may be seen as a town within the city of Malmö, and Kroksbäck with modern housing similar to large suburban areas like Stockholm's Tensta and Skärholmen and Malmö's Rosengården.

RESULTS

A total of 101 patients were referred back to the sociomedical consultant at the 4th Welfare Office. The distribution between the two areas of Kroksbäck and Limhamn was relatively even, though Kroksbäck has considerably fewer inhabitants than Limhamn.

Also regarding sex the distribution turned out to be even: 49 men and 52 women. 17 of the patients were foreign nationals and their average stay in Sweden was 4 years. The distribution of ages is shown in Table I.

That the majority are in the age group 20-49 years follows from the activities of the office. These also include investigations prior to sociomedical rehabilitation. Such evaluations, obviously, deal more often than not with the "able-bodied" ages. Consequently, this age distribution cannot be seen as characteristic of the total clientele of the social welfare office.

Inghe (1960) found, in his sociomedical charting of welfare office clients, a disproportionately large number of single persons. The same applies to our material in 1970, particularly among the women.

At the date of referral to the sociomedical consultant, 38 women were single, against 21 men. The single women often had children living at home and many were divorced.

Table II. Previous vocational training in the sociomedical cases at the 4th Social Welfare Office, Malmö, in 1970, distribution by sex.

	Men	Women	Total
Without vocational training	30	41	71
Vocational training at most in trade school; also long-term apprenticeship, etc.	14	9	23
Added vocational training	4	—	4
Information missing	1	2	3
Total	49	52	101

Circumstances while growing

Half of the subjects grew up in homes which, according to their own descriptions, were very poor, and almost half of them (43 %) have stated that alcoholism or mental illness, in a few cases also criminality, occurred in their childhood homes. In more than half of the cases persons from the subjects' own families have been known to children's care, temperance care or social relief services.

Previous vocational training and present employment situation

The women were worse off than the men in terms of vocational training and work (Table II).

At the date of referral to the sociomedical consultant only 2 of the subjects had been regularly employed throughout the last 3 years, and only 16 had worked occasionally on odd jobs. The rest were sick, unemployed, or old age pensioners. The working conditions during the three-year period immediately before the referral are shown in Table III.

Sick-listing

A prevailing trait in these clients is a high degree of infirmity. The number of sick days per year during

Table III. Work conditions in the sociomedical cases at the 4th Social Welfare Office, Malmö, in 1970: the three-year period prior to referral.

Regular employment	2
Occasion work	39
Unemployed	18
Mostly sick	18
Housewife	10
Student	2
Old age pensioner	9
Others	3
Total	101

Table IV. Somatic diagnoses in the sociomedical cases at the 4th Social Welfare Office, Malmö, in 1970.

Arthritis, arthrosis	11
Lumbago	14
Hypertonia benigna	9
Diseases of the circulatory system	10
Diseases of the nervous system and the sensory organs	9
Gastritis, ulcus ventr. et duod.	8
Accidents	7
Obesitas	6
Others	26

10 years before the date of referral averaged 56, almost thrice the average for the total population of Sweden. A total of 41 persons, at some time or other during this 10-year-period, were so-called "90-day-cases", e.g. they were sick-listed for at least one continuous period of 90 days. Over 10 years, 11 clients were sick-listed for three or more 90-day-periods. A total of 15 persons were sick-listed for more than 1 000 days per 10 year period, and 2 persons more than 2 000 days per 10 years.

Diagnosis and sociomedical problematics

Among the somatic diagnoses that emerged from the sociomedical investigation, spinal and joint complaints as well as circulatory diseases were prevalent (Table IV).

Among the *psychical* diagnoses, neuroses predominate (Table V).

Both physical and psychical infirmity show a comparatively even distribution between men and women, though with a certain preponderance of somatic diagnoses among women, and of psychic among men.

Fig. 2 shows an attempt to sum up the sociomedical "problematics" of the clients. The starting point has been Fioretos' model (Collén et al., 1970) and the results of their investigation of patients at

Table V. Psychic diagnoses in the sociomedical cases at the 4th Social Welfare Office, Malmö, in 1970.

Neuroses	48
Alcoholism	14
Psychoses	6
Mental retardation	5
Others	6

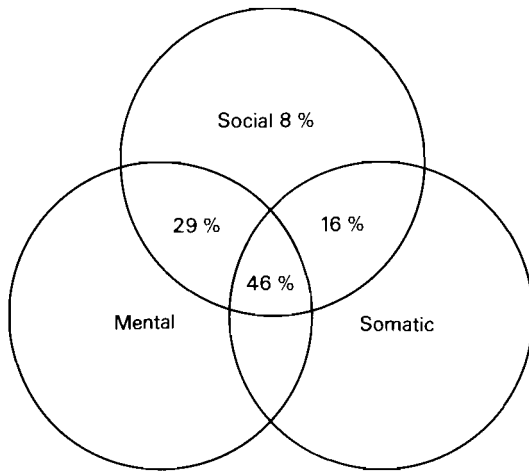


Fig. 2. The distribution of problems of the sociomedical patients at the 4th Social Welfare Office, Malmö in 1970.

the sociomedical clinic of Malmö (Bryngelsson et al., 1970). The "composite" sociomedical problems prevail, 46 % have psycho-somato-social and 29 % psycho-social problems.

Within the material only very small differences as regards problems can be discerned between clients living in the modern housing area of Kroksbäck and those in the older area of Limhamn.

DISCUSSION

In present society and because of its type of social and medical care, every social welfare office is frequented by people with grave sociomedical problems, to which no solution could be found by means of the conventional methods formerly applied within social welfare. The clients covered by this investigation had, at the date of the sociomedical investigation, been known to the social welfare administration 3 $\frac{1}{2}$ years on average, 10 of them for more than 9 years. The majority had appeared in various clinics at Malmö General Hospital in the course of many years.

The sociomedical physician enters the process only at a late stage, at which juncture the patient becomes a sociomedical case. In our opinion it would be more fortunate if open care were given greater responsibility and more time for these patients. The work requires, however, intimate cooperation with the social welfare administration and other services. This presupposes a decentralization of open care which at present is totally connected with the only hospital in Malmö, though about 40 %

of open care is attended to by private practitioners. Prevention of complicated cases and early socio-medical rehabilitation requires a medical contribution at the general practitioner level (compare Dahlin et al. 1972, 1973). With a functioning "front line" of general practitioners cooperating with district nurses, social workers and others, the socio-medical clinic should be able to function as a "specialist unit" attending to complex socio-medical problems. The clinic also should have co-ordinating functions, and in this capacity it should send its physicians on duty in various welfare offices for about 10 or 15 hours a week. The tuition and research functions would then, consequently, become central, but more stress should also be placed on sharing in planning of new housing areas and co-operative organization of open social welfare and medical care—in other words increased preventive contribution.

SUMMARY

The physicians of the Sociomedical Clinic at Malmö General Hospital each serve 10 hours a week at the local welfare offices in Malmö. The better part of the time is devoted to exhaustive examination and evaluation with a view to long-term sociomedical rehabilitation.

Here we present very preliminary results from a study of the sociomedical cases at the 4th Social Welfare Office in 1970. The sex distribution of the 101 patients was even, and the majority were in the 20–49-year age group. Single persons were predominant in the material: 38 women and 21 men. The conditions of their early years bore the stamp of poverty and alcoholism, and mental disease was frequent in their childhood homes. Most of them (71) had no *vocational training*, and for 3 years before the date of referral to the sociomedical physician only 2 had had regular employment while 39 had worked on odd jobs.

A prevailing trait was a high degree of infirmity, documented by, amongst other things, a high frequency of sick-listing. Among the *somatal* diagnoses, spinal and joint complaints as well as circulatory complaints were predominant, while neuroses were most common among the *mental* diagnoses. The composite "psycho-somato-social" and "psycho-social" problematics are clearly dominant.

The sociomedical physician enters the process

only at a late stage, thereby rendering the patient a sociomedical case. Prevention of complicated sociomedical problems and early sociomedical rehabilitation requires medical contribution at the general practitioner level.

With a well-functioning general practitioners' organization, integrated into the social welfare and other services, the sociomedical clinic will have more specialized tasks as regards rehabilitation and will be able to advance its contributions toward prevention.

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