A World Out Of Balance: Working for a New Social Balance

Physical, Emotional and Social Health

Tackling Health Inequalities Through Social Work: Analysis, Advocacy and Action

Professor Paul Bywaters

This session has a very clear and ambitious purpose: to persuade this conference and, through it, the wider social work community that tackling inequalities in health is a vital and urgent social work issue. We are looking for a transformation in the agendas of social work practice, education and research to focus attention on this pressing issue.

After this short introduction, you are going to hear from 4 colleagues who are members of the Social Work and Health Inequalities Network, of which more later. They will describe key examples from their experience in India, USA, Australia and South Africa which will illustrate how important inequalities in health are in social work service users' lives and how social work can make an impact when it focuses its attention on these issues. They will illustrate how seeing health issues through the perspective of inequalities requires a global as well as a local perspective as they talk about local manifestations of global health inequalities. They will challenge how we define health issues in our practice as social workers and illustrate how social work's responsibility to tackle health inequalities is everyone's business.

This will not leave much time for questions and discussion, but we hope that many of you will join us in a workshop immediately after the break which follows this session which is designed to give exactly that opportunity.

It is my job to lay out the key elements of our argument.

1. Health inequalities are the embodiment of unjust and avoidable human suffering; physical and emotional signs of the social injustice which social work opposes.

   There is no more powerful marker of a world out of balance than the levels and trends in life expectancy across and within nations. In several sub-Saharan African countries overall average life expectancy is below 40 years and has been falling in recent years, while in Japan and Canada it is over 80 years. Since 1993, average life expectancy in Zimbabwe has declined by 20 years from 55 to 35 years. But such inequity and the human misery it represents – the child headed households, the grief of the premature loss of a parent, a sibling a child – is not just a matter of the gap between rich and poor worlds, it is found wherever there are substantial inequalities in economic and social well-being. In Glasgow in the UK the most disadvantaged local district has a life expectancy for men of 55, while the national average is over 75. That twenty year gap is replicated in Australia between indigenous peoples (Aboriginal and Torres Straits Islanders) and the majority population. Twenty years of life lost to socially created injustice. But, of course, it

is not just the life years that are lost, but the suffering that lies behind it: living with painful chronic and life threatening illness, facing death with little or no support, being unable to secure for yourself or your family the basic conditions of human existence.

2. Health inequalities are a social work issue because the primary determinants of health are social. It is the social economic, political and environmental conditions not primarily access to health treatment and care which result in these dreadful inequalities. But access to health care is socially determined too.

   Health inequalities operate world wide and are a product of global as well as national and local forces. Studies in the UK by Michael Marmot, now the Chair of the WHO's Commission on the Social Determinants of Health, replicated throughout the world show that the gradiant in life expectancy and sickness goes right across society. It is not just that a few people who live in poverty have worse health, but every step across the social hierarchy affects your health and life chances. Health is socially patterned, importantly by social class but also by ethnicity and gender, by sexual orientation and disability. Of course, too health is linked to age, but here too, in fact perhaps here more than ever, it is the social and economic conditions in which people live that determine to a major extent whether people will live with poor health and how well they can alleviate the consequences. Raising the health of populations can only be successfully undertaken if inequalities in health are reduced. It cannot be done by focusing attention only on the few who are most disadvantaged any more than it can be done by the intervention of medical treatment or care, valuable though that often is.

3. Almost all social work service users are either already living with poor physical or mental health or their health is threatened by the conditions in which they live.

   For many service users, it is poor health which is the trigger for social work contact: in the western economies it is poor physical or psychological health in old age which triggers the need for social care resources, for younger adults physical impairments, learning disabilities, mental health problems, addictions and violence are common factors amongst those with whom social workers work. Many children we work with are failing to receive the basic conditions which create the foundation of a healthy life: good and regular food and shelter; education and exercise; physical safety, warm and loving stable relationships with adults who are also able to look after themselves. Many parents are unable to secure the conditions in which they can be a good parent and their own health is also under threat from the accompaniments of poverty: drug and alcohol abuse, smoking, poor diet, lack of healthy exercise, freedom from violence and insecurity. Because the single most common characteristic across social work service users is poverty, if health is not already damaged it is being damaged.

4. Therefore, tackling health inequalities is an issue for all social workers, not just those in health settings.

   When we argue for social workers to make health inequalities a central issue, we are not just talking to those in health settings – hospitals, surgeries, clinics –

because, as we have said, it is not primarily through health care that inequalities in health can be reduced.

Social workers not in health settings need to rethink their roles to recognise and incorporate the crucial health dimensions of their work, operating from a broad definition of health. For example, the physical health of children in residential care and of adults with learning disabilities is often very poorly attended to because professionals are focusing on other issues.

And social workers in health settings need to see their work through an inequalities lens: to recognise that accidents kill many more children than are affected by child abuse; to see violence as a physical and mental health issue not just a relationship or legal concern; to recognise the influence of childhood circumstances on health across the lifecourse; to focus on health in old age, not just taking it for granted as the backdrop to social care.

5. This is a social work practice issue, but one that requires a change in social work policy and campaigning, in education and research.

   We believe that social work can make an impact on health inequalities but that all these dimensions of social work require change to incorporate a health inequalities perspective. We believe that few qualifying programmes teach effectively about how social work can combat inequalities in health; that few researchers are focusing on the vast range of issues that health inequalities includes and we have been asked to help update IFSW policy on health so that social work can be better represented in international as well as national policy discussions.

   We also would argue that a focus on health inequalities illuminates other aspects of social work and makes us think about them differently. It sheds light on the ways in which individual lives are influenced by social structures; it requires a focus on patterns of disadvantage across populations through the development of social epidemiology, it raises questions about the relationship between anti-discriminatory practice and practice which focuses on reducing inequalities.

These issues are the focus of the SWHI Network which was founded at the last IFSW Conference in Adelaide 2 years ago. If you want to know more about our activities, come to the Network meeting on …..day at ….time or visit our website www.warwick.ac.uk/go/swhin
Via the website you can join our email list, read about the research seminars we have been running and download a fascinating set of papers that have been given.

One of the features of the development of the Network has been that members have told us that they have felt very isolated in their local situation and it has been a great relief to find that other social workers share their concern and understanding. We hope now to illustrate how this basic analysis has resonance in four very different situations across the world.

First, Professor Vimla Nadkarni …..

Then Professor Steven Rose, Dr. Lindsey Napier for Dr. Lesley Laing and Professor Vishanthie Sewpaul.