Social work in health care: An international perspective

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Abstract
An important element of contemporary social work is the influence of international trends on the contexts of practice. In this article, we will critically examine aspects of globalisation and the relationships between health inequalities and social inequalities and the implications for social work practice. Giles called on social workers to develop a ‘health equality imagination’; however, the challenge for practitioners on a day-to-day basis is how to integrate such an imagination into their work. A number of suggested approaches towards a greater engagement in addressing health inequalities in social work practice, education and research are also presented.

Keywords
Globalisation, health, health inequalities, social work

Introduction
The impact of globalisation both economically and socially on the world’s population is mirrored in trends in the health and well-being of people both between and within countries. The ‘global’ and the ‘local’ are inextricably linked. Social workers must be cognisant of these trends in their practice, trends that provide a way of understanding the social circumstances of peoples’ lives on a day to day basis, and a context within which to act. Jones and Truell (2012) note that ‘some social workers may question the relevance of a global agenda for practice in their setting’ (p. 462) but argue that ‘the dynamics of migration’ where large numbers of the world’s population are moving between countries to avoid poverty, civil unrest and environmental degradation mean that ‘no social worker will escape the reality of globalization’ (p. 462). The consequences of migration can include social dislocation and loss of traditional supports, with implications for health and well-being. Social work actions may be with individuals, groups and communities and in policy, advocacy and social change. In the recently developed document, Global Agenda for Social Work and Social Development Commitment to Action
March 2012, the International Association of Schools of Social Work (IASSW) et al. (2012) have committed members ‘to supporting, influencing and enabling structures and systems that positively address the root causes of oppression and inequality’ (p. 1). Informed by such significant initiatives as the United Nations (2012) Millennium Development Goals, the Commission on Social Determinants of Health (CSDH, 2008) and the IFSW/IASSW/ICSW Global Agenda, social work practice is now also unavoidably both local and global.

In this article, we will present an in-depth discussion of global trends that contribute to the local context for contemporary social work practice. These trends will be analysed through the lens of health inequalities. We will then discuss a number of day-to-day practice examples which illustrate these perspectives. A discussion of the implications for social work research and education is followed by concluding comments which present a series of suggested actions for social workers to incorporate these perspectives into their daily practice.

Convergence of health and social outcomes

Social and health indicators such as those used by the World Health Organization (WHO; CSDH, 2008) provide a way of comparing and contrasting health and well-being. The social origins of health and well-being involve a number of key elements. These include biological factors, individual life-course, health inequalities and different social and physical environments that lead to particular health outcomes.

Using diagrammatic methods such as ‘social’ and ‘health’ gradients, relationships between the social circumstances of people and their overall health and well-being can be illustrated. Determinants include income and financial security, housing, education, health care, sustainable environments and social inclusion. Using a horizontal axis and a vertical axis, the ‘health gradient’ shows that people on lower incomes tend to have poorer health outcomes than those on higher incomes, and the ‘social gradient’ shows that people on lower incomes tend to have poorer social outcomes including access to education, secure housing and employment. Summarising indices of health and social problems relative to the level of income equality, Wilkinson and Pickett (2009) illustrate that health and social problems are worse in countries with high levels of unequal income.1

Figure 1 illustrates that countries with a more equal distribution of income have better outcomes on many health and social indices including life expectancy, infant mortality, obesity and mental illness.

Economic indicators such as those used by the Organisation for Economic Co-operation and Development (OECD) reflect trends amongst nations and provide a way of classifying nations as ‘developed’ or ‘developing’ in economic terms. Such reports also identify the widening gap in incomes of people within countries that have traditionally had a more equitable income distribution, for example, Sweden (OECD, 2012).

In the final report of the CSDH (2008), led by Professor Sir Michael Marmot, the term ‘inequalities’ is used to describe the measurable differences in the health characteristics of individuals and groups. The Report goes on to state that

health inequities … are caused by the unequal distribution of power, income, goods and services globally and nationally. The consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns or cities – and their chances of leading a flourishing life. (p. 1)

Critical analysis suggests that the convergence of health and social inequities is also linked to power relationships in communities, both local, national and global. In work undertaken by the Commission, and more recently in England where the CSDH findings were applied in the Marmot
(2010) review, ‘Fair Society, Healthy Lives’, six domains for action were identified. These were early childhood development, education and skill development, employment and working conditions, minimum income for healthy living, sustainable communities and a social determinants approach to prevention (p. 512). The report states that many of the policies required to deliver greater health equalities should be delivered within welfare and social provision programmes, thus clearly acknowledging the centrality of social work practice to these endeavours.

It might be assumed that those countries with a history of well-developed social protection systems, delivered through models of the welfare state, would not experience significant social and health inequalities. However, in an Editorial on the European Public Health Conference in Copenhagen in 2012, Mackenbach (2012) identified paradoxical findings between models of the welfare state and social provision and the existence of inequalities, commenting that ‘contrary to expectations health inequalities are not systematically smaller in the Nordic countries’ (p. 1). The editorial goes on to state that the examination of a large literature by Beckfield and Krieger (2009) also ‘shows that the relationship between welfare regime and magnitude of health inequalities is inconsistent at best’ (p. 1). In suggesting a way forward, Mackenbach, employing a similar approach to Marmot, proposes moving back to analysing specific determinants and the social provision undertaken within countries to address them. Using the example of the health effects of unemployment, the effectiveness of a country’s individual programmes to support the unemployed through various welfare and social programmes might be examined. In making this observation based on what is currently known about inequalities, the similarities and differences highlight the complexities and ambiguities of these relationships. Nevertheless, they provide social work with opportunities and challenges to incorporate these approaches into practice, and in the health domain specifically, to incorporate global and local understandings of these processes and their social impact.
In thinking about these relationships further, the following examples illustrate the interdependence between the key factors. Inequalities are sharply illustrated in exploring the inter-relationship between health and social outcomes of Indigenous peoples in post-colonial societies, of women and children, of marginalised individuals and communities and lower socioeconomic groups in developed and developing countries and in countries with high levels of poverty.

The global picture of health in terms of physical illness and disease is also changing. In an analysis of the recently published Global Burden of Disease Study 2010 (Lim et al., 2012) significant changes have been identified in mortality within an ageing worldwide population; there are now significantly fewer child deaths from malnutrition (with the exception of parts of sub-Saharan Africa); however, there are significant increases in chronic illness, disability and mental health conditions and injuries. These are key domains for social work practice.

Indigenous peoples

In Australia, Aboriginal and Torres Strait Islander peoples experience poor health and social outcomes relative to non-Indigenous peoples. As part of the Australian government initiative, ‘Close the Gap’, the Australian Human Rights Commission (2008) has reported the life expectancy of Aboriginal and Torres Strait Islander males is 63 years which is 17 years less than that for non-Indigenous Australian males. The risk of child mortality amongst the Aboriginal population is 50 percent higher than for non-Indigenous people. Since 2005 targeted national initiatives have made small gains including the reduction of the life expectancy gap from over 20 years to 17 years, however, progress is slow as a result of historical, systemic intergenerational poverty and disadvantage.

Similarly, New Zealand has large gaps in life expectancy between Maori (Indigenous people of New Zealand) and non-Maori. These increased from a gap of about 7–8 years in the early 1980s to nearly a 10-year gap in the 1990s, but have since closed again to about 7–8 years. Mortality rates for Maori are often two to three times those of non-Maori in middle age, including all causes combined and cardiovascular disease (Blakely and Simmers, 2011).

Differing socioeconomic position between groups explains about half the ethnic differences in health. Inequalities in health appear very early on in life, and can be seen for most common causes of death, injury or hospitalisation. For example, in New Zealand, Maori babies are more than five times more likely to die of Sudden Infant Death Syndrome than non-Maori, and babies living in the most deprived neighbourhoods are six times more likely to be hospitalised with bronchiolitis (Blakely and Simmers, 2011). Suicide rates tend to be highest amongst young men, Maori, and those living in deprived areas and the prevalence of mental health issues is much higher for Maori and Pacific people (Blakely and Simmers, 2011).

Poverty in the developed and the developing world

Similar circumstances exist for people from lower socioeconomic groups in developed nations, for example, in Canada and the United States, particularly those living in poverty, on low incomes, who are members of minority groups or where other elements of disadvantage are evident. In the United Kingdom, Gypsy and Traveller families reflect similarly poor outcomes compared to the wider population (Cemlyn, 2008).

Inequalities are also apparent in societies at differing stages of economic and social development. Looking at comparative figures for life expectancy for adult males relative to income, in poorer countries such as Cambodia and the Lao People’s Democratic Republic, life expectancy is between 57 and 62 years compared with wealthier countries such as Japan, Singapore, New Zealand and Australia where it ranges from 79 to 80 years (Asia Pacific Global Action for Health Equity Network (HealthGAEN), 2011).
Networks such as the Asia-Pacific HealthGAEN (2011) have proposed action frameworks that include addressing the social determinants of health through actions that improve daily living conditions including urbanisation and environmental factors, labour and social protection, and health systems that provide sound primary health care, universal coverage and equity at all levels of service delivery. In addition, they suggest actions to address the unequal distribution of power, money and resources through the promotion of social inclusion, sound economic policy and global and regional collaboration (p. 13).

Similar themes can be found in population health movements such as the People’s Health Movement (PHM). Building on the principles of the Alma Ata Declaration (WHO, 1978) and the Ottawa Charter for Health Promotion (WHO, 1986), the importance of primary health care in the delivery of fair and equitable health services is reaffirmed through more contemporary global, public health, rights-based principles such as the People’s Charter for Health (PHM, 2012).

Within the European Union, the impact of the global financial crisis has exacerbated the underlying inequalities in wealth and health between member States (Figure 1) clearly illustrating the inherent and continuing structural systems and processes that sustain health and social inequities. Economic imperatives in the United Kingdom have resulted in health reforms such as the dismantling of the National Health Service (NHS) which have eroded health rights and universal access (Ham, 2010; Walshe, 2010). Although WHO initiatives support the development of a new health policy for Europe, the dominance of these recent economic influences are likely to impact on the immediacy of action (Marmot et al., 2012).

**Women and children**

These trends can be even more sharply illustrated when viewed through the lens of gender inequalities. Blyth (2008) highlighted significant health issues impacting on women internationally and noted that

> Even where social work is more centrally involved in reproductive health, unless its goals and concerns are also shared by more powerful interests, it risks being marginalized and is unlikely to be in a strong position to promote change without the support and endorsement of the international social work community. (p. 222)

Although the recently released World Economic Forum (2012) Global Gender Gap Report has identified a reduction of gaps in health outcomes between men and women across countries since first reporting these trends in 2006, gender equality is yet to be achieved for any indicator, with socioeconomic disparities continuing to be significant. Drawing on another global initiative, that of the Millennium Development Goal 3, sustainable development can only be achieved if gender equality and women’s empowerment are promoted in key areas including secondary and tertiary education, participation in government and civil society and economic opportunities that provide equal income attainment. The impact of reproductive health disparities provides a sharp reminder of a gender dimension in health. Jayasundara cites Singh et al. (2003: n.p.) that it is estimated that sexual and reproductive ill health accounts for one-third of the global burden of disease amongst women of reproductive age and one fifth of the burden of disease amongst the population overall. Echoing Blyth’s (2008) commentary, Jayasundara (2013) notes that reproductive health is marginalised both in the health agenda and also in the social work profession itself, claiming that it has never been a ‘mainstream social work area’ of focus, despite the many social and emotional issues arising for service-users (p. 135).

The determinants of the health and well-being of women and children are inextricably linked both biologically and socially. In a snapshot of women’s health globally, the leading cause of death and disease in women aged between 15 and 59 years is HIV/AIDS, followed closely by deaths in childbirth particularly in the developing world (WHO, 2009). Risk factors are often exacerbated by
poor access to health information and services and social norms that may influence responses. Diseases such as diabetes, tuberculosis and cervical cancer may also be linked to social as well as biological factors with their incidence relative to countries’ income levels well documented by the WHO. For example, in high-income countries, breast cancer is the leading cause of mortality amongst women (WHO, 2009).

For children, the causes of death and disease are similar for girls and boys from birth up to 9 years relative to social and economic indicators. Of particular note in childhood are the differences in the incidence of sexual violence, with girls being three times more likely to suffer sexual violence than boys. Women who have experienced sexual violence at any time in their life are more likely to be exposed to other physical health risks including miscarriages and sexually transmitted diseases but also to significant emotional distress that may lead to mental ill health, depression, anxiety, substance misuse and suicidality (WHO, 2009).

The impact of violence on women’s health and pervasively on children’s development has resulted in the WHO identifying it as a public health priority issue. Arguing strongly that violence against women is a gendered health inequality (Laing, 2009) states that globalisation has resulted in new forms of violence against women such as sex tourism and trafficking but has also led to the wider politicisation of the issue as an indicator of gendered, systemic oppression of women.

Social work perspectives that are underpinned by human rights, social justice and social inclusion are pivotal in both global and local actions that aim to alleviate health inequalities and improve the health chances and health experiences of individuals and communities. Within developing nations, social work and social development activities are recognised in the Global Agenda. At a local level, social workers can be active participants in professional interest groups that link to global health networks and movements that aim to address health inequities and act upon the social determinants of health. At all levels of practice, global and local perspectives concerning health inequalities are interwoven in daily practice.

The social work response

Amidst these seemingly overwhelming complexities that perpetuate inequities how might social workers work effectively for change? We suggest that there are some key ways social workers can integrate these understandings into their practice for the benefit of individuals, groups and communities with whom they work. Differences in the emphasis and focus of social work practice can be identified in the global context of practice. Across countries where social work in health care is a major field of practice, there may be competing emphases on social work activity for example between perspectives that are closely related to the site of medical diagnosis and treatment and other settings where social work will be development focused, aimed at reducing health inequalities.

The changing fields identified in the Global Burden of Disease study including ageing, disabilities/physical impairments, mental health and violence and the gender disparities encountered in reproductive health are key areas for social work practice in health. Social workers have a significant role to play through developing a stronger engagement with the social determinants of health in everyday practice (Craig et al., 2013).

The International Federation of Social Workers’ (International Federation of Social Workers (IFSW), 2008) statement on Health states that health ‘is an issue of fundamental human rights and social justice and binds social work to apply these principles in policy, education, research and practice’ (p. 1). With recent research identifying the importance of social experiences and circumstances of people and communities in relation to their overall health and well-being, improving the lives of men, women and children through the reduction in inequalities brings the core work of social work to these
debates (CSDH, 2008; Wilkinson and Pickett, 2009). As Bywaters et al. (2009) state, ‘Social work in all settings is concerned with the impact on people’s lives of the social forces which determine health chances and health experience … all social work has health impacts’ (p. 11). Alzate (2009) exploring where social workers encounter issues of human rights, especially for women, notes practice environments vary from technologically advanced health care facilities to social services centers to hospices to non governmental organizations to neighborhood clinics to clients’ homes and to improvised tents in places that are torn by natural or human made disasters, including war. (p. 110)

The location and style of the setting do not necessarily mitigate against human rights abuses.

The social worker in a hospital setting

The challenge for practitioners on a day-to-day basis is how to integrate these broad concepts into their work – what might it look like? In a US study, Craig and Muskat (2013) asked hospital social workers about their perceptions and developed seven major themes that described social work ‘bouncer, janitor, glue, broker, firefighter, juggler, and challenger’ (p. 4). These roles encompass a myriad of different tasks and responsibilities where social workers frequently act as a bridge between patients, families, other professionals and internal and external services. Thus, there are many opportunities to include the broader understandings of health inequalities within the core social work assessment process and documentation of actions undertaken. For example, a social worker working in a hospital may be asked to see a patient and their family needing financial assistance for travel expenses as they live in a regional area which is a long distance from the hospital. This would be considered as a routine referral by most hospital social workers. The fact that this patient and their family have experienced financial hardship as a result of inequitable access to appropriate health care for rural and regional communities is the wider social issue that has and will continue to impact on this patient’s ability to receive appropriate treatment (Alston, 2007). Having to request financial assistance may also impact on their self-esteem and sense of control over their own lives.

The referral for help with financial assistance is both an individual problem to be acted upon and also an indicator of a larger health inequity. If the patient and their family were from a lower socio-economic group, for example, or if they were an Indigenous family, more elements of the complex social circumstances would be identified in practice. In expanding the way the presenting problem is perceived to include health inequalities and systemic inequities, Giles (2009) suggests that social workers develop a ‘health equality imagination’ and that such an ‘imagination’ is necessary to encourage excellent practice in social work and perhaps avoid a narrow interpretation of the role of social work in health.

Social workers need to be aware of the cumulative impact of inequalities and inequities on the daily lives of individuals. This cumulative impact has been described by authors such as Krieger (2001) and Rose and Hatzenbuehler (2009) as the ‘embodiment’ of social class where individuals incorporate, biologically, the material and social world in which (they) live, from in utero to death; a corollary is that no aspect of our biology can be understood absent of knowledge of history and individual and societal ways of living. (Krieger, 2001: 694)

Concepts such as embodiment can be helpful to social workers in understanding the cumulative impact of intergenerational poverty and social impoverishment.

The social worker in writing up the case notes for this client and family should aim to include all these elements in their social assessment. The social assessment would be informed by theoretical frameworks and critical perspectives which contextualise the problematisation and the actions
undertaken by the social worker beyond the dominant biopsychosocial perspectives that may be evident in this practice setting.

Social work actions need to be expansive beyond the individual presenting problem and include the interpretation of ‘presenting problems’ as social situations requiring investigation through research and policy formulation, advocacy and social policy development.

Stated another way, if social workers were receiving multiple requests for such financial assistance, it may prompt them to consider undertaking research, conceptualising the problem beyond the practical need of financial assistance. Discussion with health colleagues in the interdisciplinary team would include health inequality and inequity in addition to the provision of short-term financial assistance and the ‘presenting problem’ defined by the hospital referral.

The social worker in a community setting

The ‘health equality imagination’ suggested by Giles in hospital social work practice can also be relevant in community practice. In undertaking a community assessment, social workers should consider habitat – in rural regions, towns, suburbs or large cities depending on where they are conducting the assessment. Signs of healthy and unhealthy environments including physically dangerous environments, pollution, traffic congestion, poor public transport and poor housing stock might be observed.

Within a neighbourhood, community or township, the availability and proximity of health facilities, primary health practitioners, a community clinic for children and the nearest hospital with emergency facilities might be identified. Other factors to consider include how well the community is served by the availability of facilities that support health and well-being: for example, green spaces, safe play areas for children and young people, sport and recreation, arts and culture, community facilities, health enhancement programmes for older adults and integrated and well-designed facilities for people with physical impairments.

An ecological approach to social work locates health and well-being in the physical, social, political and cultural environment. ‘Green social work’ (Dominelli, 2012) can offer a framework ensuring holistic approaches to health recognising how enduring poverty and environmental degradation can perpetuate health inequalities. Sustainability in areas of social work practice has resonance with local, national and global priorities.

The social worker in a women’s health centre

At a local women’s health centre in a community in which there are many newly arrived refugees, the social worker may see individual clients about matters regarding their resettlement concerns, financial assistance, help with accommodation and health care for their children such as immunisation and pre-school programmes. Some of the mothers may have also been referred to the centre for counselling for depression, anxiety and post-traumatic stress as a result of their experiences as asylum seekers and refugees. Once again in this practice situation, the social worker needs to ensure their practice takes on a ‘health equality imagination’. In this location, the social worker would be mindful of the wider significance of gendered violence as an underlying factor in individually constructed ‘presenting problems’ identified by the women and the centre. Working in an inclusive manner, the social worker may consult the women about their interest in attending a women’s group which may have a focus on health education and social support that is provided in a safe, culturally appropriate and trusting environment. Coming together in this manner may enable the women to form new relationships with others and find different ways to understand their experiences beyond individualised meanings or self-blame. Groupwork is a key method of social work and its use as an enabling, empowering activity can be an effective practice tool in the
incorporation of wider health inequalities focus underpinning practice at the local level. These approaches can be further supported by bringing a new perspective to social work education and the development of strong models of research informed practice, including practice-based research.

**Education and practitioner research: The widening lens**

The shift from opinion-based intervention traditions to evidence-based practice has been a challenge for social work in many countries. In Sweden, Sundell et al. (2010) have noted the challenges of developing a culture of evaluation-based intervention research, due to lack of training and academic interests. In a systematic review of Australian health-related social work research in the decades 1990–2009, Brough et al. (2013) noted the low numbers of empirical papers that were client focussed. Publications included a high number of discursive papers and ‘a significant proportion of empirical papers based on studies of practitioners rather than clients’ (p. 9). Also of significance was the absence of wider public health and health promotion research. There has been significant debate about the appropriateness of adopting a positivist approach to social work research. Van de Luitgaarden (2009), for example, posed a challenge to the effectiveness of attempting to generalise research findings in work with service users. Rather social workers tend to privilege the unique aspects of individuals and families encountered in everyday practice. From this perspective, the ‘local’ is of greatest significance especially in relation to culture, space and place, notwithstanding social workers are well placed to observe trends and patterns and offer advocacy in profiling local problems. As a consequence of tensions about research-led practice, the evidence base for social work and health inequalities remains a work in progress. Differences in the emphasis and focus of social work practice can be identified in the global context of practice, for example, Jayasundara (2013) notes that where in the west health social workers might offer individual/couple counselling in specialist services like terminations of pregnancy or infertility, in developing countries social workers are more likely to be involved in community development initiatives rolling out family-planning programmes. In a preliminary review of published research in the UK auspiced by the Social Care Institute for Excellence (SCIE) that aimed to investigate evidence of effectiveness in reducing health inequalities, no studies were found which attempted to show that inequalities in health across the population were reduced (Coren et al., 2011). Of significance, however, were the findings that there was evidence in several key areas that demonstrate the way in which social work and social care can impact on factors that contribute to health disadvantage and how these findings might inform social work education (Coren et al., 2011: 595).

Social workers in health settings find there is a constant challenge to build and maintain high visibility in both the multi-disciplinary team environment and in the public eye. One way of building better recognition of the profession’s distinctive contribution to social well-being in health settings has been identified as growing scholarly and research activity (Beddoe, 2011).

As a result of the widening lens of practice, social work students and practitioners can gain confidence in articulating the social dimensions of research inquiries including such themes as the challenges of living well with chronic illness, the support needed for recovery and rehabilitation after an accident, issues of human reproduction (unplanned pregnancy, infertility, pregnancy loss, health and sexuality), exploring disability as a social rather than purely biological condition and the needs of elders.

An integrated approach to research can include considering the interventions a social worker might employ in working with service users experiencing the health or disability challenge and their carers/families as well as issues of access and inequality. In these scenarios, exploration can draw on wide- and narrow-lens theoretical perspectives of health, for example, the social models of disability, health inequalities, biopsychosocial perspectives, ethics and social justice,
quality of life and subjective well-being. Interventions can draw from social work models and skill-sets: engagement, assessment, advocacy, counselling and support, work with couples and families, mobilising networks, community development, influencing policy and supporting self-help groups.

There are many research methods available to social workers including encouraging practitioners to work in partnerships with academic researchers. A method gaining popularity is clinical data-mining. Clinical data-mining (Epstein and Blumenfield, 2001), where researchers analyse information already routinely collected as part of practice, seems to offer great opportunities for practice-based research and has been widely undertaken in social work health studies in Australia, Hong Kong, Israel, New Zealand and the United States (Lalayants et al., 2012).

The research method provides a means of connecting social and health outcomes in a meaningful way for practice. Some useful examples include Plath and Gibbons (2010) who analysed data on single-session interventions with patients in hospital settings, and Pickett et al. (2010) who undertook a retrospective review of the final admission notes of a random sample of patients who had died in a large principal referral and teaching hospital over a 12-month period. This study investigated social work interventions in relation to deaths in hospital, widening the meaning of death from a purely clinical/biological event towards broader social understandings of the experience.

Finally in suggesting methods of including material related to health inequalities in social work education, Bywaters et al. (2009) identify the development of interprofessional teaching to mixed groups of students in professional education programmes. Interprofessional education for practice enables students to work in partnership with students from other health disciplines on specific projects and case studies learning about each other’s professional perspectives and expertise with the primary focus on the service recipient and their environment.

For social work to contribute to solutions, health needs to become more central in social work education to raise awareness of the significance of health in the well-being of all peoples. It is our contention that regardless of content, all social workers need to gain some appreciation of the significance of health inequalities and health chances during their social work education.

A ‘camera’ metaphor was utilised by Cameron and McDermott (2007) in recognition of the need for social workers to incorporate a wide view of health (inclusive of environmental, economic and geographical challenges) along with ‘middle-distance’ and ‘close-up views’ of health and well-being. A shift to integrate a wide-lens approach to health and its significance for social work is strongly advocated by the IFSW Policy Statement on Health (IFSW, 2008). Combining a narrow-lens and a wide-lens approach within social work education ensures that all social workers are exposed to information about the social inequalities of health and the impact of environmental factors.

Narrowing the lens, however, does not mean only focusing on direct practice in health settings, rather we suggest that research and theoretical understandings from social sciences can inform our practice with service users and their families in all fields of practice. This may involve a shift away from the more traditional psychological discourse of health including narrow conceptualisations of resilience and call upon our sociological imagination to think about health in terms of social impact and identity (Beddoe, 2013; Giles, 2009; Wright Mills, 2000).

A sociological approach can develop an empathetic and thoughtful approach to social work with people facing the challenges to identity created by a chronic illness (Charmaz, 1983) or the challenges of infertility and choices created by technological change (McCoyd, 2010). Social approaches recognise that illness may pose disruption to work, family life, enjoyment of social relationships, freedom of movement and many more aspects of human life. Social barriers are frequently more disabling than physical ones.
Conclusion

In this article, we have critically reviewed global trends in health and well-being through the lens of health and social inequities and the implications of these trends on social work practice in health care. In daily practice, social workers must consider how the local context of their practice is influenced by wider societal and global trends that include economic factors, the privatisation and commodification of health care, environmental degradation, climate change, political and civil unrest and violence (Bywaters et al., 2009: 12–15). These considerations must include the ways in which these factors influence their actions and priorities and their ongoing relevance to social work’s underpinning core values of social justice, human rights, fairness and the integrity of the individual. Social work practice in health must include a holistic and seamless focus on the individual and their wider social context. It is this combination that makes a significant and unique contribution to health practice, policy and the health care team.

In taking action on health inequalities and inequities, social work practice must be underpinned by socially inclusive, empowering approaches. Social workers must frame their practice around the following key elements: taking a holistic approach to people’s well-being, recognising that threats to physical and mental health are likely to affect all the people with whom they work; acting on the social determinants of health; challenging discrimination, violence, prejudice and stigma; taking into account the impact of health inequalities on the lives of individuals, groups and communities; being active participants in professional interest groups that link to global health networks; working interprofessionally ensuring the contribution of these important perspectives; researching their work and confidently communicating it to others; and seeing health work as a domain for action and advocacy locally, nationally and internationally and most importantly, that the relevance and importance of these complexities be demonstrated in their practice.

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Note

1. Further interesting and informative presentations to assist in understanding the concepts of ‘gaps’ and ‘gradients’ have been developed by Rosling (2010) and can be found at: http://www.gapminder.org/videos/200-years-that-changed-the-world-bbc/

References


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