

**Coventry University Repository for the Virtual Environment
(CURVE)**

Author name: Bywaters, P.

Title: Tackling inequalities in health: a global challenge for social work.

Article & version: Post-print version

Original citation & hyperlink:

Bywaters, P. (2009) Tackling inequalities in health: a global challenge for social work. *British Journal of Social Work*, volume 39 (2): 353-367

<http://dx.doi.org/10.1093/bjsw/bcm096>

Publisher statement:

This is a pre-copy-editing, author-produced PDF of an article accepted for publication in *British Journal of Social Work* following peer review. The definitive publisher-authenticated version: Bywaters, P. (2009) Tackling inequalities in health: a global challenge for social work. *British Journal of Social Work*, volume 39 (2): 353-367 is available online at: <http://dx.doi.org/10.1093/bjsw/bcm096>

Copyright © and Moral Rights are retained by the author(s) and/ or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This item cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder(s). The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

This document is the author's final manuscript version of the journal article, incorporating any revisions agreed during the peer-review process. Some differences between the published version and this version may remain and you are advised to consult the published version if you wish to cite from it.

Available in the CURVE Research Collection: December 2011

<http://curve.coventry.ac.uk/open>



British Journal of Social Work (2007), 1 of 15
doi:10.1093/bjsw/bcm096

Tackling Inequalities in Health: A Global Challenge for Social Work

Paul Bywaters

Paul Bywaters is Emeritus Professor of Social Work at Coventry University. He was Professor of Social Work and Director of the Centre for Social Justice at Coventry University until he retired in 2006. He is also Honorary Professor at the University of Warwick. From 2004 to 2006, he was Convenor of the Social Work and Health Inequalities Network.

Correspondence to Paul Bywaters, 1 Albany Terrace, Leamington Spa CV32 5LP, UK. E-mail: P.Bywaters@coventry.ac.uk

Summary

This paper presents arguments for recognizing and tackling health inequalities as a major new challenge for social work. Four underpinning points provide the building blocks for this case, that health inequalities are a matter of social justice and human rights, that the causes of health inequalities are primarily social, that poverty and poor health are common characteristics of social work service users and, that, therefore, health inequalities are a vital issue for social workers in all settings. A number of implications for social work practice and policy are outlined. The paper concludes that addressing health inequalities implies that social work has to become more actively engaged with critical global social, economic, environmental and political issues.

Keywords:

Introduction

In this paper, I want to argue that tackling the social causes and consequences of health inequalities should be recognized as a major new challenge for social work. As Graham wrote in the introduction to *Understanding Health Inequalities* (2000, p. 3):

This (perspective) turns the spotlight on the link between social inequality and individual health. It does so by focusing on socio-economic inequality: on the fact that how well and how long one lives is powerfully shaped by one's place in the hierarchies built around occupation, education and income.



2 of 15 Paul Bywaters

Tackling inequalities in health means ‘eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization’ (Braveman, in Task Force, 2004, p. 7). One way of describing this agenda is identified in a background paper to the 2004 World Health Organisation Ministerial Summit on Equity in Health (Task Force, 2004): 35

- integrated action to develop healthier social, economic, political and physical environments;
- improved access to appropriate universal social care and health systems;
- prioritizing interventions where ill-health and suffering is greatest and resources to address it are least. 40

The Millennium Development Goals (United Nations, 2000) reflect international agreement that inequalities in health are a major barrier to improved population health and well-being, to economic growth and to social stability (Feacham, 2000). In the UK, successive government commissioned reports and White Papers (e.g. Acheson, 1998; Wanless, 2002; Department of Health, 2004) have echoed this global emphasis on the significance of reducing health inequalities for meeting health, social and economic policy objectives. 45

However, it is only recently that theorizing *social work*’s engagement with health inequalities has begun to gain recognition in the UK as a distinctive and integral dimension of social work. This is visible both as a general topic (McLeod and Bywaters, 2000; Bywaters and McLeod, 2001) and through specific studies of, for example, domestic violence, service users’¹ perspectives on palliative care or on mental health services for young people from black and minority ethnic communities and the role of money advice services in contributing to better health (Williamson, 2000; Croft, 2006; Street *et al.*, 2004; Borland, 2004). But this focus remains a somewhat marginal influence on UK practice, policy and research. 55

Internationally, too, tackling health inequalities has become an explicit topic of social work discussion. This is reflected in the establishment in 2004 of the Social Work and Health Inequalities Network² (SWHIN) and evidenced in papers given by Network members at the International Federation of Social Work congress in Munich 2006, at the 5th International Conference on Social Work in Health and Mental Health in Hong Kong 2006 and in the ESRC-funded research seminar series on social work and health inequalities research (accessible via the SWHIN website). However, such perspectives on health-related social work remain in a minority in comparison with analyses of practice which foreground clinical skills and decision making or which draw heavily on psychological models such as those focusing on human development or loss and grief (see, e.g. the proceedings of the 5th International Conference on Social Work in Health and Mental Health, available online at www.swh2006.com). 60
65
70

In what follows, I will briefly outline why I think this focus on health inequalities is required in social work. Then, I will explore—or at least sketch out—something of what that focus on health inequalities would mean for social work



practice and policy. While most social work action will take place locally, I also 75
believe that the global dimensions of health-related policy and practice are
essential to the analysis and that view is also reflected in what follows.

Why are health inequalities a vital social work issue?

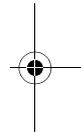
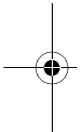
There are a number of building blocks in this argument. First, health inequali-
ties are physical and emotional signs of social injustice and the contravention of 80
human rights. There is no more powerful marker of social injustice than the
levels and trends in life expectancy across and within nations. Differences are
huge. In Glasgow, in the UK, the most disadvantaged local district has a life
expectancy for men of under fifty-five years, while the national average is over
seventy-five (Hanlon *et al.*, 2006). In several sub-Saharan African countries, 85
overall average life expectancy is below forty years and has been falling in
recent years, while in Japan and Canada, it is over eighty years (Global Health
Watch, 2005). Gaps are also growing. Since 1993, average life expectancy in
Zimbabwe has *declined* by twenty years, from fifty-five to thirty-five years. 90

But, of course, it is not just years of life that are lost that matter, but the suffer- 90
ing 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, finding yourself head of
the household when you are only a child. Fundamentally, health inequalities
are a moral issue—an issue of social justice and human rights (Nadkarni, 95
2006)—which are identified as central social work concerns in the international
definition of social work (International Federation of Social Workers, 2005).

Second, health inequalities are a vital *social work* issue because the primary 100
determinants of health are social. It is the social economic, political and environ-
mental conditions which result in these gross and demeaning inequalities, not pri-
marily access to health treatment and care (Marmot and Wilkinson, 2006; Global
Health Watch, 2005). But access to health care is socially determined, too.

Health inequalities operate worldwide and are a product of global as well as 105
national and local forces (Wilkinson and Marmot, 2003; Global Health Watch,
2005). Across the world, people's chances of a long and healthy life are prima-
rily the product of the material circumstances, particularly the income and
wealth of the family into which they are born and the range of resources and
opportunities that result. In addition, a range of other socially created aspects
of people's identities and experiences—such as their gender, ethnicity or sexual 110
orientation—affect their health chances. Of course, health is also linked to age
and to physical and cognitive abilities, but, in old age, too, it is the social and
economic conditions in which people live that determine to a major extent
whether people will die prematurely, live with poor health and how well they
can alleviate the consequences (Marmot and Wilkinson, 2006).

Although economic growth has produced substantial increases in average 115
life expectancy in many countries, often, inequalities in health have been





4 of 15 Paul Bywaters

exacerbated as social, economic and environmental inequalities have increased (for the UK, see National Statistics, 2006; for Eastern Europe, see Bobak and Marmot, 2005). As the White Paper *Our Healthier Nation* (Department of Health, 1998, p. 12) put it, ‘tackling inequalities generally is the best way of tackling health inequalities in particular’. There is increasing evidence that this 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. Studies in the UK by Marmot, now the Chair of the WHO’s Commission on the Social Determinants of Health, replicated throughout the world, show that the gradient in life expectancy and sickness goes right across societies (Marmot and Wilkinson, 2001). 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.

The deprivations that result in poor health chances are not just a matter of money. Gordon and colleagues (2003), working for UNICEF, identified eight key dimensions of child poverty: food, safe drinking water, sanitation facilities, health, shelter, education, information and access to services. Globalization increasingly influences the patterns of these core requirements wherever you live in the world (Global Health Watch, 2005). In many cases, globalization has gone hand in hand with neo-liberal economic and social policies which have dominated the thinking of major world powers and international institutions such as the World Bank. This has produced radical changes in economic patterns, generating social, economic and environmental upheavals, often triggering unprecedented migrations of populations between countries and within countries—as China is experiencing—as people are driven to move to seek a better life, or to survive at all.

And globalization has tended to exacerbate rather than reduce the chances of universal access to health care. In many countries in recent years, globalization has meant the shift from public to private health care services, and to payments for health care which mean that people are driven into poverty by poor health and unable to secure health care because of poverty (Global Health Watch, 2005).

Third, almost all social work clients or service users are either already living with poor physical or mental health or their health is threatened by the conditions in which they live (McLeod and Bywaters, 2000).

Poor health and poverty are the two conditions which most commonly characterize social work service users internationally. For those service users whose health is not yet compromised, their future health is under threat from the poverty and poor social and environmental conditions in which they live. Many children with whom social workers work 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 common accompaniments of



poverty: drug and alcohol abuse, smoking, poor diet, lack of healthy exercise, violence and insecurity. For many social work service users, poor health is the trigger for social work contact (McLeod and Bywaters, 2000). For younger adults, physical impairments, learning disabilities, mental health problems, addictions and violence are the common health-related factors underpinning contact with social workers (Davies, 2002). In old age, it is usually poor physical or psychological health which provokes the need for social care resources—poor health which often reflects the cumulative effects of disadvantage across the life course (Bywaters, 2007).

Therefore, fourth, tackling health inequalities is an issue for all social workers, not just those in health settings (McLeod and Bywaters, 2000). Because it is not primarily through health care and treatment that inequalities in health can be reduced but by tackling the fundamental causes as well as the consequences of poor health.

What are the implications for social work practice?

Tackling health inequalities, I suggest, will require some re-thinking of mainstream practice with individuals, families and communities. I make four suggestions here. In this section, I draw repeatedly on the work of SWHIN members. Recent database searches that I have been conducting (unpublished) make it clear that there is little or no hard evidence about which social work interventions have been most effective in tackling specific dimensions of health inequalities in particular contexts. What follows is necessarily an interim account; there is a major research agenda to be addressed here.

Re-focusing on the fundamental conditions for health

Certainly, as far as the UK and much of the developed world is concerned, it is important to rediscover the importance of work to improve service users' material circumstances: fundamentally, the issues of income and wealth and the associated opportunities or deprivations. As Alston (2006) has argued, globalization—including climate change—is having a dramatic effect on rural poverty in Australia and in many others parts of the world. In the UK, although poverty is a central issue identified by service users—including mental health service users—with which they would like help, this has often been defined as 'not core business' by local authority social services departments (Davis and Wainwright, 2004). However, there are counter examples, including the development of a micro-finance scheme run by credit unions in Wales (Drakeford, 2006). These offer facilities for people to make savings and to secure credit and make repayments in small weekly amounts in areas of poverty and deprivation that often lack formal banking services or where loans for banks and building societies are not available because of perceived risk. Social

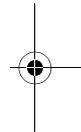
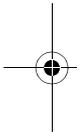


workers are being engaged to recruit families to take advantage of the credit union schemes because they are working with the kinds of families most difficult to reach, they have skills in engaging such families and because of the social work values of equality, community and supporting self-reliance. Levy and Payne (2006) have argued that welfare rights advocacy is too complex for social workers carrying other duties to undertake but that such services should be part of the range of services provided by social care teams. However, even if this argument is accepted, there are roles for social workers in raising awareness, making referrals and ensuring successful linkage to advocates in the case of service users who are under extreme pressures, as well as in arguing for such expertise within their service area.

Beyond income and wealth, social workers in many countries should consider whether the people they work with have the basic building blocks of health, such as clean water, fresh air and nutritious food. Nadkarni (2000) has described the application of social work methods to secure a garbage collection system for a slum community in Mumbai, India. But these issues do not just apply in developing countries, where they are likely to be particularly acute, and in post-Communist countries, but for sections of the population in developed countries, too. There are many problems relating to what in the USA is called 'food insufficiency' (Siefert *et al.*, 2001). Social care services provide food in many settings: residential and day-care; meals on wheels; soup kitchens; to foster-children, and should be aware of the significance of nutrition in such settings. Social workers work in hospitals where—in the UK, for example—several studies have demonstrated that older people in hospitals are at risk of becoming malnourished because they are physically unable to eat food that is provided and no adequate help is offered (Age Concern England, 2006). People who are socially excluded or on the margins face multiple problems with securing adequate nutrition, and there are many wider issues linked to food, such as the relationship between food and mental health, food and violence, food and the ability of children to concentrate in schools, as well as increasing concerns about obesity, particularly amongst disadvantaged populations (Siefert *et al.*, 2001). Willows (2005) has recently written about the problem of obesity in indigenous children in Canada, arguing that discrimination against First Nation children is seen in the lack of good data and in the lack of attention to the cultural meanings attached to eating and weight and to perceptions of weight-related illnesses such as diabetes.

Taking a life-course perspective

Second, greater attention should be paid by practitioners to how disadvantage impacts on health across the life course: how disadvantage at one point in a person's life can have knock-on effects later on and how both the primary causes and the secondary effects can be combated (Davey Smith, 2003). Stephen Rose (2006) in the USA has been demonstrating that people who have

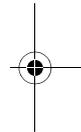
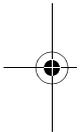




suffered from severe disadvantage in childhood are less likely to be able to make good use of conventional mental health programmes in adult life and that such programmes need to be adapted to include such populations. 245
Another of the Network's members was part of a group who compared the response to heart surgery between people who had and had not suffered in the holocaust many decades earlier (Schreiber *et al.*, 2004). This means rediscovering the value of focusing on service users' personal histories and learning to interpret the impact of these on their lives and capacities. 250

Recognizing the health content of social issues

Many social workers do not recognize—and, therefore, do not pay attention to—the health content of much of their work. For example, most social workers concerned with domestic violence would not consider themselves health workers but both the physical and mental health consequences and accompaniments 255
of such violence on the women (usually) and their children is considerable but often neglected in favour of more immediate issues of safety and separation from the perpetrator (Humphreys, forthcoming; Evans-Campbell *et al.*, 2006). Similarly, social workers have, over long periods, paid inadequate attention to the health of children in the care system, contributing to the cumulative disadvantage that those children and young people face (Bywaters, 1996). Recognizing 260
the importance of this aspect of care has led to the appointment of specialist nurses for looked after children in Scotland, working alongside social work teams. A recent study by Greaves and Mulholland (2006) demonstrated both how inadequately social workers were dealing with this—often, there was no 265
health information on file, no record of medications, no evidence of vaccinations completed, no useful health checks completed—and how well this could be transformed by awareness training backed up by the expert support of the nurse.



Re-focusing practice from individuals and families to populations

In order to see and respond to inequalities in health, we also have to shift some 270
of our attention from individuals and families to populations. The data-mining research technique developed for health-related social work by Joubert and Epstein (2005) is a method for making this shift in focus. This is how Greaves and Mulholland started: with an audit of the health needs of the population of children and young people in the care system. In the USA, Oktay has 275
developed work on the individual consequences of breast cancer by examining *patterns* of breast cancer mortality between African-American and white American populations. She discovered that there is a substantial inequality in cancer outcomes, partly because of different patterns in access to screening (unpublished paper presented at the IFSW Congress Munich, 2006). She identified 280
multiple reasons for this which are mainly social and economic at root;





8 of 15 *Paul Bywaters*

some concern individuals' understandings and low expectations developed across the life course; some the costs of accessing health care; some the availability of services. These led to a variety of new issues for social workers to be concerned about in their work with African-American women who are at risk. Raamat (2006) in Estonia has been following a very similar path—looking at the inequalities in cancer death rates between Estonia and other European countries and the growing inequalities within Estonia between rich and poor, urban and rural, more educated and less educated populations, those with health cover and those without. This also led her to look at patterns in help-seeking behaviour and how early cancer was likely to be diagnosed in different social groups. Like Oktay, she argues that social workers have to respond to these socially patterned inequalities at both the individual and the population levels.

From protection to prevention

Child protection has been at the centre of social work practice in developed countries over the past three decades, beginning with a focus on physical abuse and extending to sexual abuse. This focus on protection has now been extended to social work approaches to work with older people (Brown and Stein, 1998). Clearly, this is an important issue, but has the focus on what used to be called 'non-accidental' injuries prevented social workers from perceiving the importance of accidental injuries and other causes of illness, impairment and death in childhood and adult life? Deaths in accidents run at about four times the level of homicides in the UK (Home Office, 2004). Childhood injuries in the UK have a very strong association with poverty and poor living conditions. Roberts and Power (1996) reported that children in social class V were fifteen times more likely to die in a house fire than children in social class I and five times more likely to die in a road accident as a pedestrian. So, why have social workers not been concerned about this much greater level of avoidable injury and premature death? Similarly, in the UK, between 25,000 and 55,000 excess deaths amongst older people have occurred in winter each year for the last decade, primarily because of the combined effects of housing that is difficult to heat and fuel poverty (Healy, 2003). Again, this massive avoidable loss of life has not been a focus of systematic social work action, although the majority of older people in contact with social workers will be at risk due to poverty and poor environmental conditions. Social workers are reported by a fuel poverty adviser to frequently argue that this is not their concern (Saran Jarvie, National Energy Action worker in Coventry, personal communication).

What are the implications for policy work?

In this section, I want to begin by discussing policy intervention within one country before considering global issues. As will already have become apparent,



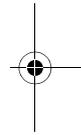
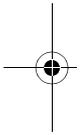
the health inequalities agenda involves multiple kinds of social policy issues. These can be conceptually divided into two types: creating the conditions for equitable health and securing equitable access to treatment and care.

Creating the conditions for equitable health

I have already discussed some of the practice issues linked to primary prevention of poor health. Although, in the UK and—from the evidence of social work journals—internationally, social workers are not greatly engaged in anti-poverty work, the creation of both welfare systems and opportunities to earn adequate income through work are necessary, if not sufficient, conditions for greater equity in health. In the UK, the best examples of social work-related policy work to reduce poverty are currently being seen in Wales (Drakeford, 2006). Drakeford—a social work academic turned government policy adviser—has worked to develop locally based anti-poverty initiatives which have secured government support by demonstrating their impact. The first is the micro-credit scheme outlined above. A second example is the placing of money advice workers in GP surgeries, focusing particularly on the financial needs of older people and people with mental health problems. They have demonstrated that for every £1 spent by the government to fund the scheme, £5 is going into the pockets of people who were not otherwise claiming their minimum level of benefits. In these and other examples, a social work knowledge of the dynamics of poverty in the lives of individuals and families, complemented by a structural analysis and skills in negotiating political and policy making obstacles, has proved a valuable asset in developing effective solutions.

Securing equitable access to treatment and care

Struggles to secure and maintain access to health and social care services and, particularly, equity of access to treatment and care are almost universal across the world. In countries with universal health care systems, supposedly provided free at the point of access, such as the UK and Scandinavia, there are constant policy battles to maintain both universality and equity. For example, in the UK, dental care has been privatized by stealth, with substantial proportions of the population unable to access an NHS dentist, and other much needed services (such as eye care, chiropody and physiotherapy) are also rationed by lack of supply and often by charging systems, even when provided by the state health care system (Shepherd *et al.*, 1996). Age-based discrimination is built into health care decision making by the widespread use of the notion of quality-adjusted life years, such as in the approval of prescription medicines. Alongside overt rationing policies which create inequalities in access, there are widespread informal, institutional practices which mean that some minority ethnic groups, in particular, as well as others, such as travellers (Van Cleemput, 2000;





10 of 15 Paul Bywaters

Cemlyn and Briskman, 2002), homeless people (Kushel *et al.*, 2001) and prisoners (Butler and Milner, 2003), get a second-class service. 360

In countries *without* universal, free health services, the situation is much worse, of course, with people in poverty often unable to secure health care and people who are ill often having being forced into poverty in order to secure treatment (Global Health Watch, 2005). This has been described for China by 365 another member of the Network who has identified a number of potential entry points for social work intervention:

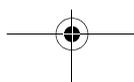
- public education in providing information to the disadvantaged groups, like migrant workers and older retired people, helping them to make informed choices; 370
- forming self-help groups of people suffering chronic illness to facilitate mutual support;
- advocacy by identifying loopholes and sensitizing government and the general public on issues of inequality relating to health;
- networking with relevant government departments and concerned medical practitioners to conduct policy analysis; and 375
- evaluation research in order to identify the underlying social, economic and political factors of inequality, proposing evaluation tools and making suggestions for proactive solutions to problems and long-term development (Law, 2006). 380

As Law says, there are a variety of opportunities for social workers to engage at the national and local policy levels, including through research. Similarly, in the USA, Perloff (1996) has argued that social workers have the possibility not only to assist individuals to make best use of Medicaid-managed care systems, but also to advocate for access to care for disadvantaged populations. 385

Global policy development

However, increasingly, many policies, including policies affecting access to health care (see Global Health Watch, 2005), are not determined primarily at the local or national levels and can only be influenced by action on the international stage. The issues here are many and complex, and that is leaving aside 390 the question of how social work can secure influence. The Global Health Watch report for 2005/06 identifies some of the major concerns that influence people's health across the globe:

- the world economic order;
- the costs and consequences of warfare and violence; 395
- climate change;
- the role and operations of international pharmaceutical companies;





- the protection of access to fundamental human knowledge such as the human genome;
- the drain of health and social care professionals from developing to developed countries.

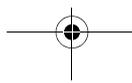
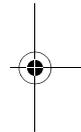
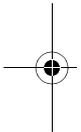
As yet, there is too little evidence of social work involving itself with these issues for them to be explored in detail.

However, while most social work activity will continue to operate mainly at the local and individual levels (Payne, 2006), I suggest that social work should not ignore the moral and practical challenges that the global policy context represents. Of course, social work has little or no power globally, but it has exercised relatively little energy even on understanding how a greater role might be secured, how alliances might be sought or built, how influence might be earned or how global movements might be supported or fostered. The International Federation of Social Workers has accreditation at the UN as a non-governmental organization—but not at the WHO—and a small team of volunteer advocates who operate in that forum. That is not an impressive organizational response from an internationally recognized profession, with over eighty countries having national organizations of social workers involving around half a million members.

Conclusions

In working on the development of the Social Work and Health Inequalities Network, my awareness of health inequalities has been enhanced and changed by the perspectives of members from other countries. In part, this has made me more aware of my relative health advantages, but it has also reinforced such sense as I had that those very advantages are built in part on others' disadvantages: on others' poverty wages, on the relative power of the 'north' in international forums, where issues of trade, security, health and other policies are determined, on the capacity of the UK to attract foreign professionals to staff our health, social care services and other services.

For me, a focus on social work's commitment to tackle health inequalities forces us to look 'upstream'—to think about what we can do to tackle causes as well as ameliorating the consequences of socially created injustices that threaten not only quality of life but life itself. In a globalized world, social work has to become more critically engaged in promoting a health equity agenda with international issues through our national governments and through social work's representatives in international organizations, as well as in our individual involvements. Of course, social work cannot act alone. We need to work with others who share similar values and goals. But, here, our record is again not good. Social work is also not visible (and, of course, I have to include myself in this) in the alternative global social movements working for more equitable health: the People's Health Movement; Global Health Watch; the Global Forum for Health Research. We claim as a profession to be engaged in





12 of 15 Paul Bywaters

the empowerment of ordinary people but we have shown no serious political
engagement with these major movements.

440

Social work will not be the central player in building new international
arrangements, but, to be true to its code of ethics, social work has a moral obliga-
tion to act when and where it can to oppose, reduce and mitigate the causes and
consequences of health inequalities. There is growing evidence (indicated
above) of small-scale interventions by social workers making a difference. But
much greater awareness of the importance of health inequalities in service users'
lives and of the potential for social work to act to combat these is required. In
turn, this requires a sea change in the profession's perceptions of the purpose
and function of health-related social work. There are some signs of national and
international action by social workers to address the major policy issues but
these need to be greatly strengthened and developed. The inequalities that I
have been discussing threaten not only individual people's health, but the future
stability of the world's political and economic and ecological systems. The unjust
conditions that undermine health also undermine human rights more generally,
they undermine the chance of humanity living peacefully with each other and,
ultimately, they threaten the very survival of human life on planet Earth.

445

450

455

Accepted: June 2007

Notes

1. The term 'service users' is employed throughout to describe the range of people with or for whom social workers work or might work, including those not seeking, not receiving or refusing services. No terminology is currently universally acceptable or entirely satisfactory.
2. The Social Work and Health Inequalities Network, which has around 150 members from more than fifteen countries across the world, was founded in 2004 as a result of discussions at the 4th International Conference on Social Work in Health and Mental Health in Quebec. At the Conference, Stephen Lewis (the UN envoy on HIV AIDS in Africa) challenged social work to make its presence felt in international policy-making forums and to argue for global health justice. The Network is, in part, a response to that challenge and it exists to link social workers in different parts of the world who want to promote and discuss social work practice or policies or research or education that actively combats inequalities in health. For more information about the Network, go to www.warwick.ac.uk/go/swhin.

References

- Acheson, D. (1998) *Independent Inquiry into Inequalities in Health*, London, Department of Health.
- Age Concern England (2006) 'Hungry to be heard: The scandal of malnourished older people in hospitals', available online at www.ageconcern.org.uk/AgeConcern/Documents/Hungry_to_be_Heard_August_2006.pdf.

- Alston, M. (2006) 'Globalisation, rural restructuring and health service delivery: Policy failure and the role of social work', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/esrc_seminar_series/seminar_2/alstonpaper.pdf.
- Bobak, M. and Marmot, M. (2005) 'Social and economic changes and health in Europe East and West', *European Review*, **13**(1), pp. 15–31.
- Borland, J. (2004) *Better Advice, Better Health: Final Evaluation Report*, Gwynedd, Bangor, Citizens Advice Bureau and University of Wales.
- Brown, H. and Stein, J. (1998) 'Implementing adult protection policies in Kent and East Sussex', *Journal of Social Policy*, **27**, pp. 371–96.
- Butler, T. and Milner, L. (2003) *The 2001 New South Wales Inmate Health Survey*, Sydney, NSW Corrections Health Service.
- Bywaters, P. (1996) 'Government, social services departments and the health of children and young people: Which way forward?', *British Journal of Social Work*, **26**(6), pp. 777–92.
- Bywaters, P. (2007) 'Understanding the lifecourse', in Lymbery, M. and Postle, K. (eds), *Social Work: A Companion to Learning*, London, Sage.
- Bywaters, P. and McLeod, E. (2001) 'The impact of New Labour health policy on social services: A new deal for services users' health?', *British Journal of Social Work*, **31**(4), pp. 579–94.
- Cemlyn, S. and Briskman, L. (2002) 'Social (dys)welfare within a hostile state', *Social Work Education*, **21**(1), pp. 49–69.
- Croft, S. (2006) 'Social work and health inequalities: A palliative care perspective', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/esrc_seminar_series/seminar_1/croftpaper.pdf.
- Davey Smith, G. (2003) *Health Inequalities: Lifecourse Approaches*, Bristol, The Policy Press.
- Davies, M. (ed.) (2002) *The Blackwell Companion to Social Work*, Oxford, Blackwell.
- Davis, A. and Wainwright, S. (2004) 'Combating poverty and social exclusion: Implications for social work education', *Social Work Education*, **24**(3), pp. 259–73.
- Department of Health (1998) *Our Healthier Nation*, London, Department of Health.
- Department of Health (2004) *Choosing Health*, London, Department of Health.
- Drakeford, M. (2006) 'Does equality matter? Poverty, social work and making a difference in health', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/esrc_seminar_series/seminar_1/drakefordpaper.pdf.
- Evans-Campbell, T., Lindhorst, T., Huang, B. and Walters, K. L. (2006) 'Interpersonal violence in the lives of urban American Indian and Alaska Native women: Implications for health, mental health, and help-seeking', *American Journal of Public Health*, **96**(8), pp. 1416–22.
- Feacham, R. G. A. (2000) 'Editorial: Poverty and inequity: A proper focus for the new century', *Bulletin of the World Health Organization*, **78**(1), pp. 1–2.
- Global Health Watch (2005) *Global Health Watch 2005–2006: An Alternative World Health Report*, London/New York, Zed Books.
- Gordon, D., Nandy, S., Pantazis, C., Pemberton, S. and Townsend, P. (2003) *Child Poverty in the Developing World*, Bristol, The Policy Press.
- Graham, H. (2000) *Understanding Health Inequalities*, Buckingham, Open University Press.
- Greaves, E. and Mulholland, R. (2006) 'Addressing the unmet health needs of accommodated children & young people through health and social work inter-agency partnerships', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/esrc_seminar_series/seminar_3/elaine.doc.

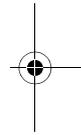
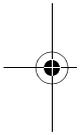
14 of 15 Paul Bywaters

- Hanlon, P., Walsh, D. and Whyte, B. (2006) *Let Glasgow Flourish*, Glasgow, Glasgow Centre for Population Health.
- Healy, J. D. (2003) 'Excess winter mortality in Europe: A cross country analysis identifying key risk factors', *Journal of Epidemiology and Community Health*, **57**(10), pp. 784–9.
- Home Office (2004) *Crime in England and Wales 2002–3: Supplementary Volume 1, Homicide and Gun Crime*, London, The Home Office.
- Humphreys, C. (forthcoming) 'A health inequalities perspective on violence against women', *Health and Social Care in the Community*.
- International Federation of Social Workers (2005) 'Ethics in social work: Statement of principles', available online at www.ifsw.org/en/p38000324.html.
- Joubert, L. and Epstein, I. (2005) 'Multi-disciplinary data-mining in allied health practice', *Journal of Social Work Research and Evaluation*, **6**(2), pp. 139–41.
- Kushel, M. B., Vittinghoff, E. and Haas, J. S. (2001) 'Factors associated with the health care utilization of homeless persons', *Journal of the American Medical Association*, **285**, pp. 200–06.
- Law, A. (2006) 'Marketisation, fee charging, and inequity of the health care system in mainland China', available online at www2.Warwick.Ac.Uk/Fac/Cross_Fac/Healthatwarwick/Research/Devgroups/Socialwork/Swhin/Esrc_Seminar_Series/Seminar_2/Agnepaper.Pdf.
- Levy, J. and Payne, M. (2006) 'Welfare rights advocacy in a specialist health and social care setting: A service audit', *British Journal of Social Work*, **36**(2), pp. 323–31.
- Marmot, M. and Wilkinson, R. (2001) 'Psychosocial and material pathways in the relation between income and health: A response to Lynch *et al*', *British Medical Journal*, **322**, pp. 1233–6.
- Marmot, M. and Wilkinson, R. (eds) (2006) *Social Determinants of Health*, Oxford, Oxford University Press.
- McLeod, E. and Bywaters, P. (2000) *Social Work, Equality and Health*, London, Routledge.
- Nadkarni, V. (2000) 'Interventions on garbage pollution using integrated social work practice framework', available online at www.anthro.umontreal.ca/varia/beaudetf/proceed/ftp_files5/Nadkarni.pdf.
- Nadkarni, V. (2006) 'The human rights perspective in health social work', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/activities/vimla.ppt.
- National Statistics (2006) 'Life expectancy at birth by health and local authorities in the UK 1991–1993 and 2002–2004', available online at www.statistics.gov.uk/downloads/theme_population/LE_Report_2005.pdf.
- Payne, M. (2006) 'International social work research and health inequalities', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/esrc_seminar_series/seminar_1/paynepaper.pdf.
- Perloff, J. D. (1996) 'Medicaid managed care and urban poor people: Implications for social work', *Health and Social Work*, **21**(3), pp. 189–96.
- Raamat, K. (2006) 'Social epidemiology as a theoretical framework to identify determinants of late cancer detection in Estonia: A social worker's perspective', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/esrc_seminar_series/seminar_2/raamat.pdf.
- Roberts, I. and Power, C. (1996) 'Does the decline in childhood injury mortality vary by social class? A comparison of class-specific mortality in 1981 and 1991', *British Medical Journal*, **313**, pp. 784–6.



Tackling Inequalities in Health 15 of 15

- Rose, S. (2006) 'Using life course epidemiology to inform social work research and practice', available online at www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/devgroups/socialwork/swhin/activities/rosepaper2.doc.
- Schreiber, S., Soskolne, V., Kozohovitch, H. and Deviri, E. (2004) 'Holocaust survivors coping with open heart surgery decades later: Posttraumatic symptoms and quality of life', *General Hospital Psychiatry*, **26**(6), pp. 443–52.
- Shepherd, J. P., Thomas, D. W. and Shepherd, P. (1996) 'Privatising the NHS: Dentistry paves the way', *British Medical Journal*, **312**, pp. 922–3.
- Siefert, K., Heflin, C. M., Corcoran, M. E. and Williams, D. R. (2001) 'Food insufficiency and the physical and mental health of low-income women', *Women Health*, **32**(1–2), pp. 59–77.
- Street, C., Stapelkamp, C., Taylor, E., Malek, M. and Kurtz, Z. (2004) *Minority Voices*, London, Young Minds.
- Task Force on Health System Research Priorities for Equity in Health (2004) 'Priorities for research to take forward the health equity policy agenda', World Health Organisation, available online at www.who.int/rpc/summit/en/index8.html (accessed January 2005).
- United Nations (2000) *United Nations Millennium Declaration: General Assembly Resolution 55/2*, available online at www.un.org/millennium/declaration/ares552e.htm (accessed January 2006).
- Van Cleemput, P. (2000) 'Health care needs of travellers', *Archives of Disease in Childhood*, **82**, pp. 32–7.
- Wanless, D. (2002) *Securing our Future Health: Taking a Long Term View*, London, HM Treasury.
- Wilkinson, R. and Marmot, M. (2003) *The Solid Facts: The Social Determinants of Health*, Copenhagen, World Health Organisation.
- Williamson, E. (2000) *Domestic Violence and Health*, Bristol, The Policy Press.
- Willows, N. (2005) 'Overweight in Aboriginal children', *Journal of Aboriginal Health*, **2**(1), pp. 76–86.



Acknowledgements

Although this paper is not her responsibility, I would like to acknowledge my debt to Eileen McLeod, with whom I have had innumerable discussions of these issues. A version of this paper was first presented to the 5th International Conference on Social Work in Health and Mental Health, Hong Kong, December 2006. I am grateful for the support received from the Conference Organisers.

