# SOCIAL WORK, HEALTH AND EQUALITY

Eileen McLeod and Paul Bywaters

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# Social Work,
# Health and Equality

Deepening health inequalities, the restructuring of the welfare state involving the fragmentation of social work as a recognisable discipline and popular disaffection with health and welfare professionals underline the need to rethink social work's contribution to people's health.

In three main ways *Social Work, Health and Inequality* suggests what social work can contribute to people's health:

- the magnitude of the profound and unjust human suffering which arises from the impact of social inequalities on health should be a matter of urgent concern to social workers.
- through focusing on this problem, social work can make a significant contribution to more equal chances and experiences of health and illness.
- to make such an impact requires major shifts in the conceptualisation, practice and organisation of social work.

*Social Work, Health and Equality* will be essential reading to trainees and professionals in social work and health care.

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## The State of Welfare
Edited by Mary Langan

Throughout the Western world, welfare states are in transition. Changing social, economic and political circumstances have rendered obsolete the systems that emerged in the 1940s out of the experiences of depression, war and social conflict. New structures of welfare are now taking shape in response to the conditions of today: globalisation and individuation, the demise of traditional allegiances and institutions, the rise of new forms of identity and solidarity.

In Britain, the New Labour government has linked the projects of implementing a new welfare settlement and forging a new moral purpose in society. Enforcing 'welfare to work' on the one hand, and tackling 'social exclusion' on the other, the government aims to rebalance the rights and duties of citizens and redefine the concept of equality.

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# Social Work,
# Health and Equality

Eileen McLeod and Paul Bywaters

To Anna McLeod and Bruce and Margaret Bywaters

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## Series editor's preface

State welfare policies reflect changing perceptions of key sources of social instability. In the first half of the twentieth century – from Bismarck to Beveridge – the welfare state emerged as a set of policies and institutions which were, in the main, a response to the 'problem of labour', the threat of class conflict. The major objective was to contain and integrate the labour movement. In the post-war decades, as this threat receded, the welfare state became consolidated as a major employer and provider of a wide range of services and benefits to every section of society. Indeed it increasingly became the focus of blame for economic decline and was condemned for its inefficiency and ineffectiveness.

Since the end of the Cold War, the major fear of capitalist societies is no longer class conflict, but the socially disintegrative consequences of the system itself. Increasing fears and anxieties about social instability – including unemployment and homelessness, delinquency, drug abuse and crime, divorce, single parenthood and child abuse – reflect deep-seated apprehensions about the future of modern society.

The role of state social policy in the Clinton–Blair era is to restrain and regulate the destructive effects of market forces, symbolised by the Reagan–Thatcher years. On both sides of the Atlantic, governments have rejected the old polarities of left and right, the goals of both comprehensive state intervention and rampant free-market individualism. In its pursuit of a 'third way' the New Labour government, which came to power in Britain in May 1997, has sought to define a new role for government at a time when politics has largely retreated from its traditional concerns about the nature and direction of society.

What are the values of the 'third way'? According to Tony Blair, the people of middle England 'distrust heavy ideology', but want 'security and stability'; they 'want to refashion the bonds of community life' and, 'although they believe in the market economy, they do not believe that

the only values that matter are those of the market place' (*The Times*, 25 July 1998). The values of the 'third way' reflect and shape a traditional and conservative response to the dynamic and unpredictable world of the late 1990s.

The view expressed by Michael Jacobs, a leading participant in the revived Fabian Society, that 'we live in a strongly individualised society which is falling apart' is widely shared (*The Third Way*, Fabian Society). For Jacobs, the fundamental principle of the 'third way' is 'to balance the autonomous demands of the individual with the need for social cohesion or "community"'. A key New Labour concept that follows from this preoccupation with community is that of 'social exclusion'. Proclaimed the government's 'most important innovation' when it was announced in August 1997, the 'social exclusion unit' is at the heart of New Labour's flagship social policy initiative: the 'welfare to work' programme. The preoccupation with 'social exclusion' indicates a concern about tendencies towards fragmentation in society and a self-conscious commitment to policies which seek to integrate atomised individuals and thus to enhance social cohesion.

The popularity of the concept of social exclusion reflects a striking tendency to aggregate diverse issues so as to imply a common origin. The concept of social exclusion legitimises the moralising dynamic of New Labour. Initiatives such as 'welfare to work', targeting the young unemployed and single mothers, emphasise individual responsibility. Duties – to work, to save, to adopt a healthy lifestyle, to do homework, to 'parent' in the approved manner – are the common themes of New Labour social policy; obligations take precedence over rights.

Though the concept of social exclusion targets a smaller section of society than earlier categories such as 'the poor' or 'the underclass', it does so in a way which does imply a societal responsibility for the problems of fragmentation, as well as indicating a concern to draw people back – from truancy, sleeping rough, delinquency and drugs, etc. – into the mainstream of society. Yet New Labour's sympathy for the excluded only extends as far as the provision of voluntary work and training schemes, parenting classes and drug rehabilitation programmes. The socially excluded are no longer allowed to be the passive recipients of benefits; they are obliged to participate in their moral reintegration. Those who refuse to subject themselves to these apparently benign forms of regulation may soon find themselves the target of more coercive interventions.

There is a further dimension to the 'third way'. The very novelty of New Labour initiatives necessitates the appointment of new personnel and the creation of new institutions to overcome the inertia of the established structures of central and local government. To emphasise the importance of its drugs policy, the government has created the new office of Drugs Commissioner or 'Tsar', and prefers to implement the policy through a plethora of voluntary organisations rather than through traditional channels. Health action zones, education action zones and employment action zones are the chosen vehicles for policy innovation in their respective areas. At higher levels of government, semi-detached special policy units, think-tanks and quangos play an increasingly important role.

The *State of Welfare* series aims to provide a critical assessment of social policy in the new millennium. We will consider the new and emerging 'third way' welfare policies and practices and how these are shaped by wider social and economic changes. Globalisation, the emergence of post-industrial society, the transformation of work, demographic shifts and changes in gender roles and family structures all have major consequences for patterns of welfare provision.

Social policy will also be affected by social movements – the demands of women, minority ethnic groups, disabled people, as well as groups concerned with sexuality or the environment. *The State of Welfare* series will examine these influences when analysing welfare practices in the first decade of the new millennium.

Mary Langan
February 1999

# Acknowledgements

# Chapter 1

# Inequalities in health

## A social work issue

**NTRODUCTION**

Physical health is a site of social inequality. Unequal social relations create unequal chances of staying alive, unequal possibilities of health across lifetimes and inequalities in the experience of ill health. Profound, unjust suffering results. Social work in its own right can contribute to changing this situation: to creating greater equality in physical health. Yet this dimension to practice has barely gained recognition within social work, despite its crucial importance for people's well-being. In this book we examine the devastating impact of social inequalities on physical health, how social work generally – not simply in health care settings – may tackle this, and how such practice can be developed.

We focus specifically on health inequalities as a key issue for social work, for three fundamental reasons:

- The unjust, unnecessary suffering resulting from socially-constructed inequalities in physical health should be a cause of concern to social workers.
- Social work is implicated in processes which produce and maintain such inequalities.
- Social work can make its contribution to a more equal experience of physical health.

We now introduce each of these main themes in turn.

# HEALTH INEQUALITIES:
# A CAUSE FOR CONCERN

## A major social problem

Reducing health inequalities, primarily through addressing social inequalities, became central to the rhetoric of health policy following the advent of the Labour administration in 1997 (Department of Health (DoH) 1997a and 1998a).[1] Moreover social work, through independent sector and statutory social services, was seen to have a key role to play in this, with local authority departments being given joint lead responsibility with the NHS for meeting health inequality targets (DoH 1998b). However, these developments should not be read as representing a thoroughgoing, explicit and informed engagement on the part of social work with tackling social inequalities to promote greater equality in physical health. In social work discourse in the UK, attention to physical health – never mind the consequences of practice for health inequalities – remains marginal, as it has been over the past thirty years (Bywaters 1986 and 1996; McLeod and Bywaters forthcoming). Moreover, social work's general concern with different dimensions of oppressive social relations has not resulted in consideration of inequalities in physical health. Yet this constitutes a major social problem, characterised by widespread, pervasive suffering.

In Chapter 2 we detail how socially created and socially constructed inequalities in health have a profound impact on people's lives. At its most stark, social conditions affect how long people live. Nor are differences in life expectancy a matter of a few weeks or months. In 1991–3, men aged 20 in Social Class I had a life expectancy five years longer than men in Social Class V (Smith 1996). 'People may appreciate what a five-year gap in life expectancy means by understanding that if we were to cure cancer then life expectancy in Britain would go up by only about three years' (Macara, quoted in Smith 1996: 9).

These pronounced differences in life chances in the UK according to people's socio-economic position are found throughout the age range. A child's chances of dying in the first year of life are twice as great in Social Class V as in Social Class I. Children in Class V are almost five times as likely as a child in Class I to die from being hit by a car, over eight times as likely to die from a fire, over twice as likely to die from a respiratory condition (Roberts and Power 1996).

Not only is life expectancy linked to social circumstances but there are also extensive inequalities in people's chances of experiencing serious illness. Steep class-gradients are apparent across most major long-term and life-threatening illnesses, including heart disease, stroke, respiratory disease and lung cancer, with widespread and devastating effects on people's lives.

> For example, in 1996 among the 45 to 64 age group, 17 per cent of professional men reported a long-standing limiting illness compared to 48 per cent of unskilled men. Among women, 25 per cent of professional women and 45 per cent of unskilled women reported such a condition.
>
> (Independent inquiry (The Acheson Report) 1998: 14)

Multiple dimensions of social inequality and discrimination crosscut health. These result not only in unequal chances of maintaining good health but also in inequalities in accessing treatment, in securing the resources necessary to recovery or to a good quality of life in cases of serious illness, and in receiving high-quality care in terminal illness (Arber and Ginn 1991; Graham 1993; Grande *et al*. 1998; Marmot and Shipley 1996; Nazroo 1997). For example, the Acheson Report (1998: 99) concludes that:

> people from minority ethnic groups are more likely … to: find physical access to their general practitioner (GP) difficult; have longer waiting times in the surgery; feel that the time spent with them was inadequate; and be less satisfied with the outcome of the consultation.

We can become immune to such findings, but they are evidence of lives cut short, or lived with unnecessary suffering and struggle.

## Lay health work against powerful odds

The complex and intimate consequences of social inequalities for physical well-being are further revealed in the way they permeate 'lay health work'. (Stacey 1988). While the contribution of health and social care professionals is significant, the bulk of the work of maintaining health and managing illness, as we will show throughout, is done by lay health workers – lay people working on a day-to-day basis for their own or other people's health. For example, as Graham's (1993) work has revealed,

mothers parenting in poverty are constantly making hard choices about how they will meet their children's needs for the food, shelter and care which are fundamental to their health. Such choices, when constrained by inadequate material resources, may paradoxically draw the women concerned into apparently 'unhealthy' behaviours:

> 'I buy half a pound of stewing meat or something and give that to Sid and the kiddies and then I just have the gravy – before I used to buy soya things and substitutes to meat but I can't afford that now.'
>
> (Graham 1993: 160)

> 'When they are all screaming and fighting in here and in the kitchen, I'm ready to blow up so I just light up a cigarette. It calms me down when I'm under so much stress.'
>
> (Graham, 1993 : 182)

As reflected here, in grappling day in, day out with the damaging effects on health of social inequalities, lay health workers are engaging with powerful social forces. The first of these is the economic system as a whole, which impacts directly on health chances through the unequal distribution of income and wealth, as well as through inequitable opportunities for work and job security. The second is the 'health industry', which feeds into and compounds socially created inequalities in health. The large and growing commercial health market, for example, exploits the notion of individualised responsibility for health through the promotion, at a premium, of 'healthy food', over-the-counter medication, the 'fitness/beauty' industry and private health care. This 'commodification' of health, as Crawford (1980) has described it, creating the expectation that health can (and should) be purchased, has a powerful ideological function as well as reinforcing inequalities in health according to the ability to pay.

A third social force with adverse consequences for equalising health chances, put simply, combines two functions identified as being fulfilled by the state in the context of capitalism. These are to foster 'accumulation and legitimation'.

> Under the first function, the state has to maintain and promote those social and economic circumstances in which profitable private capital accumulation can take place. However, under the function of

legitimation, the state must attempt to preserve and promote the general conditions of social harmony.

(Turner 1995: 179)

The significance of these roles was exemplified in the performance of the Conservative government in the UK across the 1980s and 1990s. Policies favouring the 'accumulation' agenda resulted in widening inequalities in the distribution of material and social resources (see Chapter 2). Accumulation was enhanced by government measures to – for example – control public expenditure, such as the detachment of state pension increases from average earnings; keep down wage levels, through sanctioning high rates of unemployment; transfer responsibility from the NHS to means-tested social services and to informal care; and promote private health and social care (Bywaters and McLeod 1996a). These developments were associated with a consequent widening in health chances between advantaged and disadvantaged sections of society (Wilkinson 1996a). Yet while instrumental in tilting the odds against physical well-being for large sections of the population, the government's discourse was characterised by a diversionary emphasis on health as a matter of personal responsibility or irresponsibility (DoH 1992) and by the use of health 'variations' as the officially preferred term to neutralise evidence of structurally created inequalities (DoH 1995a).

## SOCIAL WORK: COMPOUNDING HEALTH INEQUALITIES

Inequality in physical health requires attention from social workers because of the gravity of the damage it inflicts on people's welfare and because of its socially constructed nature. It also demands attention because social work is itself implicated in the processes which produce and maintain such inequalities. We analyse this tendency in detail in Chapters 3 to 6. Here we indicate the extent to which it is institutionalised in practice.

### A neglected issue at the heart of practice

Professional social work has shown a lack of awareness of the issue of inequalities in physical health despite the significance of this issue in

the lives of the vast majority of its own service users, in whose experience the unequal social conditions which have such threatening and damaging effects on health are almost universal. Although there is relatively little systematic analysis of contact with social workers by social status (partly because most service users exemplify those groups not well recognised in statistics based on the employment of the male head of the household: Graham 1995) there is evidence of extensive poverty and deprivation. For example, studies in Strathclyde in the 1980s found that around 80 per cent of all service users were living on social security benefits and most on means-tested benefits (Becker 1997). Most children enter the care system from a family living in poverty (Bebbington and Miles 1989), while families with disabled children are disproportionately likely not to have the material resources to be able to sustain a healthy standard of living (Joseph Rowntree *Findings* 1998a).

Moreover, the few studies which analyse the health of service users show that the majority are either currently living with illness or caring for someone in poor health, often jeopardising their own health in the process. Corney's (1985) analysis of referrals to a generic intake team found that less than 10 per cent were free from physical symptoms, while almost two-thirds described themselves as suffering from a profound health problem. Redmond *et al.* (1996) investigated untreated health problems in seventy-seven older people receiving home care. Sixty-eight were assessed as likely to benefit from further intervention. In total 192 referrals were made. Studies of the outcome of caring for someone with a long-term illness in the absence of adequate material and personal support consistently demonstrate adverse consequences for carers' health (Anderson and Bury 1988; Spackman 1991).

## A problematic record

Although the negative association between social inequalities and health is manifest in the lives of users of its own services, social work's record of addressing such situations is problematic. This is epitomised in the following two issues. First, social work has failed to implement measures to combat poverty as a consistent and central feature of practice (Becker 1997; Davis and Wainwright 1996), while too often adopting a pathologising, individualistic approach (Jones 1997). In Clark and Davis' (1997) survey of social workers' approaches to poverty, a depressing picture of the absence of even preliminary

engagement with this issue was found. Limited awareness of poverty as a social problem and its significance in the daily lives of service users was accompanied by underestimation of levels of debt. Attempts to maximise income were far from routine – not surprising when almost half the employers questioned did not regard addressing relative poverty as an appropriate role for social workers.

Second, social work's record has also proved questionable in ensuring equality in access to, and in the experience of, the community-based domiciliary day-care and residential services which provide much-needed sources of practical, emotional and social support for people living with ill health. To give one example, successive studies have shown differential levels of information about services between minority ethnic groups and the majority population, and amongst minority groups in general. Coupled with institutionalised barriers to access this has resulted in inequalities in the use of mainstream services, not adequately compensated for by a 'special projects' approach which has often been dependent on temporary and vulnerable funding arrangements (Butt and Mirza 1996).

## A bad situation exacerbated

Moreover, through the role assigned to it by state policies social work has been sucked into exacerbating social inequalities, with adverse consequences for health. As highlighted earlier, through the 1980s and 1990s state policies in Britain intensified social and economic inequalities. This process was also marked by a developing programme designed to individualise, domesticate, privatise and commercialise health and welfare provision, resulting in a worsening experience of ill health for the least powerful members of society. Social workers were drawn into this process of restructuring the state's role in welfare provision. This led to such trends in local authority social work as: gatekeeping increasingly inadequate financial resources; targeting at the expense of prevention; and a narrowed repertoire of intervention reflecting a more bureaucratised approach (Lymbery 1998; Means and Smith 1998; Parton 1996).

Despite identifying social work as necessary to its programme for tackling health inequalities, current welfare policy is characterised by some significant continuities with that of the previous administration. There remains a strong emphasis on individual, family and

community responsibility; a focus on containing risk and dangerousness; and an expectation that social workers will act as managers of rationed provision with narrow eligibility criteria. Within this conception social work continues to occupy an 'essentially contested and ambiguous position … between the respectable and the dangerous classes' (Parton 1996: 6); a balancing act characterised as protecting the vulnerable, while not undermining the independence of the private citizen in providing for their own and their family's welfare. This approach is manifest in the government white paper 'Modernising Social Services'(DoH 1998c) and linked policy documents which emphasise the management and regulation of social care provision rather than a substantial redistribution of material and social resources to underwrite service users' welfare.

## SOCIAL WORK: CONTRIBUTING TO GREATER EQUALITY IN HEALTH

### A positive contribution

Uncovering social work's complicity in perpetuating inequalities in physical health is a necessary prerequisite for establishing how social work in its own right can make a positive impact. In Chapters 3 to 6 we set out social work's positive contribution to greater equality in physical health. This is evident across four key dimensions: health creation and maintenance (Chapter 3); the experience of illness at home (Chapter 4); ill health in hospital (Chapter 5); and facing life-threatening illness (Chapter 6). In exploring each of these dimensions we:

- examine the conditions under which lay health work is carried out;
- discuss internal and external obstacles to social work intervention; and
- analyse examples of, and possibilities for, social work practice contributing to greater equality in health.

We demonstrate that only if social work redresses social disadvantage and explicitly tackles health inequalities can it play a significant role in producing more equal chances of physical health and greater equity when ill.

Characteristic elements of the type of practice which brings this about are:

- a direct contribution to increasing the material, environmental, personal and social resources required: for example, maximising income, securing safe appropriate accommodation, strengthening interpersonal and social support and improving access to information;
- collaboration in building up the infrastructure of interest groups, locality-based activism or self-help organisations in the interests of redressing discrimination; and
- advocacy and brokerage with the professionals concerned to ensure greater equity in accessing available professional care and treatment and in the quality of care received.

We do not focus on the social construction of mental health, which has already been the subject of considerable attention in social work. However, in addressing inequalities in physical health we are not endorsing a false mind-body dichotomy (Bendelow 1998). This reflects our view that the boundaries between physical health and the experience of emotional well-being are permeable. Our discussion testifies to the extent to which physical and emotional experiences interact as conduits of the adverse effects of oppressive social relations.

## Social work 're-formed'

Notwithstanding the limitations outlined earlier, the current policy context is more favourable for social work's contribution to the objective of reducing inequalities in health than under the previous administration. First, as we have already mentioned, the current government is on record as giving high priority to tackling the impact of social inequalities on health as a central plank of health (and social services) policy (DoH 1997a, 1998a and 1998b). This recognition has been underlined by a number of connected policy statements and initiatives. Health inequalities are a focus for Health Action Zones (HAZs) (DoH 1997a), Health Improvement Programmes (HImPs) (NHS Executive 1998) and Primary Care Groups (PCGs) (DoH 1997a).

In addition, these initiatives involve a series of structural changes and operational imperatives which are designed to transform