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13

Social Work and Health

Paul Bywaters and Cindy Davis

INTRODUCTION

The IFSW's international policy on health opens with the assertion 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. All people have an equal right to enjoy the basic conditions which underpin human health. These conditions include a minimum standard of living to support health and a sustainable and health promoting environment. All people have an equal right to access resources and services that promote health and address illness, injury and impairment, including social services. (IFSW, 2008)

In this summary statement, health social work is placed unequivocally within the international context of human rights, reflecting the UN Universal Declaration of Human Rights adopted in 1948, and is distanced from a *primary* concern with medicine or healthcare services. Social work's contribution to health has come a long way since one early writer stated that

> It is essential to make it clear from the outset that the social worker is part of the medical organisation. She (sic) is one means of diagnosis and treatment. She is not to pursue independent sociological or statistical enquiries. She is not to be the agent of any other non-medical society (Cabot 1919, quoted in Bywaters, 1986: 663).

These shifts in focus, from the medical to the social, from the technical to the ethical, from illness to health, from treatment to rights, from individual to policy intervention are echoed in this chapter on the internationalisation of health social work since its emergence in the hospitals of USA and European urban areas at the end of the 19th century (Bell, 1961; Bywaters et al., 2009).

We begin the chapter by setting the context and exploring the key concepts in international health and social work. In the core of the chapter we exemplify these themes through the discussion of four key global health issues: illnesses, people, providers and activism[1].

SETTING THE CONTEXT

A brief recent history of international health concerns

The establishment of the World Health Organization (WHO) in 1946 marked a key

point of development for health policy. Embedded in the constitution of the WHO were statements which have framed thinking about health in the period since the second world war and which have established the international context of health policy and practice. First, the Constitution created a definition of health which has become widely used, including in a recent International Federation of Social Workers (IFSW) policy (see later). While it is not immune from criticism, the idea that 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946: 1) was crucial in three key respects: it emphasised positive health rather than the relief of illness; it recognised that physical and mental health were inextricably connected; and it saw that health had a central social component. Second, the constitution declared that the 'enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'. By agreeing that health was a fundamental right, signatory countries accepted – separately and together – an obligation to act to protect and promote population health. Moreover, the benchmark for success was set at the 'highest attainable' level not merely a minimum standard. And, third, by explicitly rejecting the idea that anyone should be discriminated against because of their identity or social circumstances, the Constitution established the importance of inequities in health between and within populations.[2]

In 1978 the Alma Ata Declaration called for 'Health For All' by the year 2000 and both re-affirmed and significantly developed the principles of the original WHO Constitution. The central feature of the Declaration was that it called for primary healthcare to be at the heart of healthcare systems, 'bringing healthcare as close as possible to where people live and work, and constitut(ing) the first element of a continuing healthcare process'(WHO, 1978: 1). The current Director General of the WHO,

Margaret Chan, recently called for a return to this vision (*Lancet*, 2008). The Declaration explicitly castigated the 'gross inequality' in health between and within countries and named a range of social and economic determinants only implied in 1948. For example, it linked expenditure on armaments and warfare with a call for governments to make resources available for health. Although influential in public health thinking, the Declaration's call for a new economic order actually coincided with the start of a period of over 20 years when neo-liberal economic policies held sway as globalisation accelerated (Labonte and Schrecker, 2007a).

In the 1980s and 1990s it was another institution formed in the post-war years, the World Bank, which seemed to dominate international health policy making, in alliance with the International Monetary Fund (Labonte and Schrecker, 2007a,b,c; Global Health Watch, 2005). Pushing policies which required economic liberalisation of developing countries' markets as the price of aid, the World Bank was responsible for the dismantling or erosion of already fragile public sector services in health and social care in many developing countries, and for the promotion of the role of profit making transnational companies selling a variety of health related products including healthcare services, health insurance and pharmaceutical and other treatments. But, as became increasingly clear by 2000, neo-liberal economics had an even more damaging effect on the wider social determinants of health, creating widening inequities in health outcomes across the globe (Commission on the Social Determinants of Health, 2008). Poverty, food insecurity and environmental degradation went hand in hand with a failure to secure improved educational outcomes, water, sanitation and other elements of an infrastructure for health. For instance, the liberalisation of the economy of the former Soviet Union saw a rapid deterioration in life expectancy (Bloom and Canning, 2000) and it also became clear that HIV/ AIDS thrived under conditions of neo-liberal globalisation, with

devastating results for millions of people (see later) (Altman, 1999; Bancroft, 2001).

The end of the 20th century saw evidence of growing political pressure to reverse these health-damaging policies, leading to the formation of the Millennium Development Goals (UN, 2000) and the start of a period in which contradictory ideologies have rivalled each other for power. So, to give a few examples of issues with wide international resonance:

- There have been extended struggles over the power and autonomy of pharmaceutical companies, their control over patents, their desire to restrict the production of 'generic' rather than branded preparations and their pricing policies.
- New large global charitable trusts, such as the Gates Foundation, have entered the political and health arenas, often focusing on single diseases, with different commentators drawing different conclusions about whether their impact was positive or provided a smoke screen for 'business as usual'.
- Popular social and health movements have increasingly acted to protest against the impact of globalisation on health.
- The WHO established the Commission on the Social Determinants of Health which boldly asserted that 'social justice is a matter of life and death' (CSDH, 2008: Preface) and that global health inequities were immoral as well as economically inefficient.
- The global financial crisis of 2008 plunged many people into poverty and contributed to instability in food security, while other health damaging social trends – many forms of migration; war, terrorism and violence; climate change; the promotion of private healthcare services and insurance – continued without effective international intervention.

Global economics and globalised health systems exert both a direct and indirect impact on health social work today. Social workers find themselves dealing with the consequences of migration; of environmental degradation; of health tourism, human and organ trafficking; of war and political conflict, as well as poverty (Bywaters et al., 2009). Financial pressures – to cut costs and make profits – threaten the capacity of social workers to act in the interests of service users' health in health settings (Sulman et al., 2001) and non-health settings alike (Ferguson, 2008). However, the emergence of new social movements, such as the People's Health Movement (http://www.phmovement.org/en) and AIDS activism in the health arena; and service user, mental health survivor and disability activism in the social sphere offer scope for new alliances for social workers working for health, locally and internationally.

Current health outcomes and determinants

As Mary Robinson has argued in founding the global 'Realizing Rights' organisation (www.realizingrights.org) the right to life is the most fundamental human right. Mortality rates are also the starkest markers of health outcomes. In the lifetime of the WHO, life expectancy has substantially increased in most countries of the world. As Table 13.1 shows, average life expectancy at birth in developed countries has increased by over 10 years in the last 50 and continues to do so. In these countries it now stands at around 80 years, with countries enjoying greater social equality doing better than those which are more unequal (Wilkinson and

Table 13.1 Average life expectancy at birth 1960–65 and 2005–10

	1960–65	2005–10
Angola	34	47
Australia	71	82
Brazil	56	72
China	50	73
Costa Rica	63	79
Japan	69	83
South Africa	50	52
USA	70	79
Zimbabwe	52	44

Source: United Nations Department of Economic and Social Affairs, Population Division, World Population Prospects: The 2008 Revision, New York, 2009.

Pickett, 2009). China, with a rapidly expanding but managed economy, is one of the mid-range countries in terms of development which have tended to show larger increases but from a low base. China, Brazil and Costa Rice all have experienced an increase in average life expectancy of over 15 years in the last 50. But while some amongst the poorer countries have kept pace, others, especially those in sub-Saharan Africa, but also war-torn countries like Afghanistan, have failed to do so. In the worst cases, such as Zimbabwe, life expectancy has actually fallen so that inequalities in life expectancy between the most and least advantaged countries have grown. In summary, there are immense differences in the length and quality of people's lives largely – but not exclusively – a product of the wealth of the country in which you happen to be born and how that wealth is distributed.

Table 13.2 demonstrates even greater levels of inequality between countries. In the most developed countries only around five children in a thousand will die before they reach their fifth birthday. In the least developed countries, usually again those where structural poverty is combined with internal conflict or war, one in five will die; 40 times as many. Maternal mortality rates vary even more alarmingly from under 10 deaths per 100,000 births in most developed countries in 2005, to over 1500 in the worst places to have a child, according to WHO data (UN data, 2010). These statistics raise significant issues of children and women's rights not just in the countries affected but also globally in terms of international economic and development policies and practices.

Table 13.2 also shows the big differences in survival rates between boys and girls in different countries. In some countries, the differential risks which boys are exposed to result in greater male mortality, but in others, where girls are less valued, their lives are also at risk. In China, for example, girls have a 40 percent higher under-five mortality rate. Other inequities in health outcomes within countries are also great, and in many cases growing, even in the global north. As the Commission on the Social Determinants of Health (CSDH, 2008) highlighted, the poorest district in a city in Scotland (Glasgow) has an average male life expectancy in the mid-50s, while in nearby districts it is in the high 70s. The sometimes grossly negative outcomes for indigenous peoples and disadvantaged ethnic or other minorities, even in countries with universal health services such as Canada and Australia, also reinforce the argument that it is social, economic, environmental and political factors rather than healthcare services that determine these health outcomes (Bywaters et al., 2009).

It is not only that there is a gap between rich and poor, every step up the ladder of income and wealth is reflected in better average health outcomes as Marmot's (2004) research demonstrated. This gradient in health means that equalising health outcomes cannot be achieved by only targeting those in the worst economic circumstances, as the problem is not one of a gap but of a slope.

The WHO Commission on the Social Determinants of Health, after an exhaustive examination of the evidence, was very clear about the causes of these distressing inequalities.

Table 13.2   Estimated mortality under five per 1000 live births, 2005–10

	2005–10	2005–10	2005–10
	Both sexes combined	Males	Females
Angola	205.0	220.4	189.2
Australia	5.6	5.9	5.2
Brazil	29.1	33.1	24.9
China	29.3	24.6	34.9
Costa Rica	11.4	12.8	9.9
India	81.5	77.3	86.0
Japan	4.3	4.6	3.9
South Africa	71.7	79.5	63.8
USA	7.3	7.2	7.6
Zimbabwe	94.2	99.8	88.5

Source: United Nations, Department of Economic and Social Affairs, Population Division, World Population Prospects: The 2008 Revision, New York, 2009.

<mark>The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries 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 healthcare, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries</mark> (CSDH, 2008: 1).

It is the official recognition of social determinants worldwide which opens up the potential for social work to build alliances with other professions and other actors. The recent Strategic Review of Health Inequities in England Post-2010 (Marmot, 2010: 159), for the first time in a quasi-official document, made the link between the disadvantaged lives of most service users and their poor health and acknowledged the potential of social workers to 'make a significant contribution to health and to health inequalities'.

We turn next to the efforts being made within social work to address health issues at the international level, starting with the IFSW policy statement.

INTERNATIONAL HEALTH SOCIAL WORK

International Federation of Social Workers Policy on Health

The major initiative in recent years to create the basis for international action on health issues by social workers is the policy statement on health of the IFSW (2008; http://www.ifsw.org/p38000081.html), summarised in seven key propositions:

1 Health is a key aspect of all fields of social work – practice, education, research and policy making – and in all settings.
2 Health is not merely the absence of disease, it encompasses physical, mental, emotional and social wellbeing.
3 Health is a central dimension of people's lives.
4 Health is an issue of fundamental human rights.
5 Health status is primarily determined by social, economic, environmental and political conditions and is an issue of social equality and justice.
6 Securing and sustaining health depends on local, national and global health and social policies and practices.
7 Securing and sustaining health depends on the concerted actions of international institutions, governments, civil society and peoples.

The full version of the policy contains a statement of the main issues for social work's <mark>role in health, and a background analysis as</mark> well as an extended account of these seven key points.

The origins of the statement can be seen in the WHO constitution discussed earlier, in that it adopts the holistic definition of health and asserts that health is an issue of human rights and social justice. It also endorses the thrust of the CSDH in focusing attention on the social determinants of health: 'the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness' (CSDH, 2008: Preface). A number of other key points follow from these central planks of the policy.

The first is that health is *all* social workers' business, whatever setting or organisation they work in, because social work addresses the social determinants of health. Almost all those who use social work services – in all work settings and all countries – are either those whose physical and/or mental health is already poor or whose future health is threatened by the poor social and environmental conditions in which they live, and

have lived across their lifecourse (McLeod and Bywaters, 2000). Many social workers, moreover, specifically work in the international health sphere. Front line social workers in U.N. agencies (e.g. UNICEF) and in international non-governmental organisations (INGOs; e.g. Oxfam, Project Hope, International Red Cross) are faced with providing direct services around the globe to those most in need (Jones, 2000; NASW, 2011).

Second, by arguing that health is a central dimension of people's lives, the policy is not only saying that health matters a great deal to people – which, of course, it does – it is saying that, whenever possible, people work for their own health on a daily basis. Stacey (1988) suggested that everyone is a lay health worker, in terms of choices about what to eat and drink, whether to take medication or exercise, working to get health back after illness or hospitalisation, and balancing work and leisure. Many people also manage the health of children, partners, parents, relatives and friends at the same time. This lay health work – work people do for their own health and as informal carers of others – is the majority of health work and without it the healthcare professionals' work would be much less effective. Social professionals and development workers in both the global North and South often recognise the importance of lay health work and that lay health workers are experts on their own lives and their own health. However, social workers in some settings fail to recognise the health dimensions of their work or perceive health related social work only as a specialist role. In the global North, informal carers, including children, are often relied on by welfare systems and the commitment of social care staff is exploited (Becker, 2007) while in the global South, informal care is likely to be the norm in the absence of well developed health and social work services.

Third, the right to health includes the right to the resources which underpin health, to universal affordable basic healthcare, and the right to participate in decision making about health at the individual and policy

levels. That is why IFSW opposes unregulated, market driven economic policies which convert health from a right to a commercial opportunity. When health is a commodity, unnecessary treatments are sold, people put their own lives at risk to make money from their bodies, and the quality of the healthcare they can receive becomes a function of how much money they earn or how much wealth they can command (Blyth, 2009). That is why the policy states that it is governments, rather than the market, which must lead health policy making and why social workers should intervene in policy making processes at every level as well as through direct practice with individuals, groups and communities.

Fourth, securing and sustaining health depends on concerted international action. Because the context for health social work is increasingly global, responses must be global too. So the policy argues that social workers must hold governments to account for the commitments they have already made to the universal right to health in collaboration with others who share social work's values and objectives. Central also must be alliances with those who use health services, or who would if they could afford them, and with the global and local popular health movements. However, the capacity of IFSW to pursue this policy internationally is very limited and it has no permanent official standing with the WHO.

Other international structures and opportunities

Since the mid 1990s, a series of conferences under the title of 'Social Work in Health and Mental Health' have been held in various parts of the world. These have provided a major platform for discussion and debate across national boundaries with over 200 papers being given at the conference in Dublin in 2010. The impetus for these conferences came from social workers in Australia, Israel and the USA who met at the pioneering Mount Sinai Leadership

Enhancement Programme initiated by Helen Rehr (Nilsson and Wellington-Boyd, 2006) which has itself been a powerful medium for exchanges albeit mainly between staff from the same three countries. One by-product of these conferences has been the establishment of the Social Work and Health Inequalities Network (www.warwick.ac.uk/go/swhin), with over 200 members from 17 countries in 2011. The network aims to promote discussion and action by social work practitioners, managers, educators and researchers to combat the causes and consequences of unjust and damaging socially created inequalities in health. It has produced books and special issues of journals, run international seminars, had a significant presence at conferences and led the re-writing of the IFSW policy. There are other international health related social work associations, notably the Association of Oncology Social Work (http://www.aosw.org/html/about.php) with over 1000 members, (mainly in the USA). Another example is the Academic Network of European Disability experts (ANED) created by the European Commission in December 2007 with the aim of establishing and maintaining a pan-European academic network in the disability field that will support policy development in collaboration with the Commission's Disability Unit (http://www.disability-europe.net/en/about%20us).

There are two major US journals with a specific focus on health social work, *Social Work in Healthcare* and *Health and Social Work*, which accept a few international articles in English. But there is little exchange, for example, between social workers in South America and those in developed, western nations, and few published accounts of health social work in Africa where health outcomes are so markedly poor.

KEY ISSUES

We now explore the themes discussed above through the discussion of four key global health issues: illnesses, people, providers and activism. These four issues were selected because they cross national boundaries and impact health on a global level. Although it is possible to discuss any given health topic on a national or regional level, it is appropriate here to give examples of these topics from the vantage point of their impact on a global level.

Illnesses

The spread of infectious diseases is probably one of the most recognisable global health issues attributable to diseases such as HIV/AIDS, malaria, TB, SARS, swine flu, and West Nile virus. Social workers around the globe are involved in the treatment and impact of these illnesses on individuals, families, communities, and nations. The mobility of today's society elevates epidemic risks as diseases rapidly spread across borders (Lyons et al., 2006). To take one example, the AIDS epidemic is unparalleled in its effects on the global community. Since the beginning of the epidemic, almost 60 million people have been infected with HIV and 25 million people have died from HIV-related causes (UNAIDS, 2009). Despite available global resources to fight this epidemic, HIV and AIDS have an impact worldwide, as illustrated in Table 13.3.

There are several trends that shape the global epidemiological curve, including factors such as geographical region, an increasingly mobile global population, gender inequality, age, and access to antiretroviral medications (UNAIDS, 2009; Coovadia and Hadingham, 2005). Gender plays a key role in the prevention and transmission of HIV. Early in the epidemic, HIV infection and AIDS were primarily diagnosed in men, but today, the HIV/AIDS epidemic represents a growing and persistent health threat to women around the globe (UNAIDS/ UNFPA/ UNIFEM, 2004). Women now represent half of all adults living with HIV/AIDS, with the percentage as high as 60 percent among

Table 13.3   Regional statistics for HIV and AIDS, end of 2008

Region	Adults and children living with HIV/AIDS	Adults and children newly infected	Adult prevalence*	Deaths of adults and children
Sub-Saharan Africa	22.4 million	1.9 million	5.2%	1.4 million
North Africa and Middle East	310,000	35,000	0.2%	20,000
South and South-East Asia	3.8 million	280,000	0.3%	270,000
East Asia	850,000	75,000	<0.1%	59,000
Oceania	59,000	3900	0.3%	2000
Latin America	2.0 million	170,000	0.6%	77,000
Caribbean	240,000	20,000	1.0%	12,000
Eastern Europe and Central Asia	1.5 million	110,000	0.7%	87,000
North America	1.4 million	55,000	0.4%	25,000
Western and Central Europe	850,000	30,000	0.3%	13,000
Total	33.4 million	2.7 million	0.8%	2.0 million

*Proportion of adults aged 15–49 living with HIV/AIDS.

Source: UNAIDS (2009) AIDS Epidemic Update: Global Facts and Figures. World Health Organization.
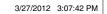
young women between the ages of 15 and 24. Due to a combination of gender inequality, power theory and socio-economic factors, some women may be unaware of their male partners' sexual behaviour or feel powerless to insist on condom use or negotiate safe-sex practices due to fear of repercussions to the relationship including abuse or abandonment (MacMaster et al., 2008). The problem is further compounded by the fact that infected women can pass the infection to a baby during pregnancy, delivery, or breastfeeding. In 2008, approximately 430,000 children were born with HIV, the total estimate of children under 15 living with HIV increasing to over 2 million (UNAIDS, 2009). It is essential to address these factors when implementing HIV and other health prevention programmes for women around the globe.

The last decade has witnessed an unprecedented increase in access to HIV treatment through antiretroviral therapies (ART). Between 2003 and 2008, access to antiretroviral drugs in low and middle income countries rose 10-fold, helping to decrease the number of HIV-related deaths (UNAIDS, 2009). However, although industrialised countries have been reaping the benefits of ART for many years, results are only recently beginning to emerge in resource-limited countries. For example, Africa is experiencing significant public health benefits associated with improved treatment access. In the Western Cape Province of South Africa, six-month mortality among patients at an HIV treatment centre fell by roughly half (from 12.7 percent to 6.6 percent) following the introduction of ART (Boulle et al., 2008), and northern Malawi witnessed a population-level reduction in mortality of 35 percent among adults following the introduction of ART (Jahn et al., 2008). But, despite considerable progress, global coverage remains low with only 42% of people in need of treatment having access to ART. Furthermore, only 38% of children from developing countries in need of treatment received ART in 2008 (UNAIDS, 2009).

Notwithstanding some positive gains, there is a significant shortfall in the resources and funds available to fight various infectious and non-infectious diseases and the future outlook is grim. The global economic downturn has resulted in a flatline for contributions (UN News Centre, 2010). The lack of funds and resources to fight these epidemics is resulting in millions of people being denied access to prevention and treatment, including women, young people and children. Health systems in developing countries

are often unable to cope with the demands being placed on them to distribute funds, while single-disease funding can result in distortions in health systems and a lack of aid being delivered effectively to those most in need (Coovadia and Hadingham, 2005).

Social workers are trained to address human rights issues and are uniquely placed within a wide variety of health and welfare settings to make an effective contribution to the global effort to address infectious diseases, such as HIV/AIDS, malaria and TB (IFSW, 2007). Rather than an illness specific approach, they can contribute to capacity building and systematic strengthening of health systems aimed at reducing the inequities in healthcare delivery between resource-rich and -poor countries (Coovadia and Hadingham, 2005). In many countries, social professionals partner with allied health and mental health providers to build a continuum of care for those individuals, families and communities attempting to cope with the impact of both infectious and non-infectious diseases. Globally, social work must engage increasingly in advocacy to ensure that health issues are recognised by service providers and policy makers so that development efforts take into account awareness, prevention and treatment as priority areas in national and international systems and policies (IFSW, 2007).

People

The increased mobility of people has significant implications for health issues and health systems. The cross-border exchange of health workers and health services are changing the dynamics of health delivery systems around the world. One of many aspects of these processes is health tourism (Blyth, 2009). Health tourism is on the rise as national borders become more open and as healthcare cost and availability continue to vary between countries around the globe. Wealthy patients from developing countries have long travelled to developed countries for high quality medical care, and a growing number of less-affluent patients from developed countries are now traveling to regions once characterised as 'third world', seeking high quality medical care at affordable prices (Herrick, 2007). Reports on the number of patients travelling abroad for healthcare are scattered. It is estimated, however, that approximately 250,000 foreign patients sought care in Singapore, 500,000 in India and as many as 1 million in Thailand during 2005 (Herrick, 2007). Healthcare tourism travels all ways, not simply rich to poor, but also rich to rich, and poor to rich for specialised treatments. Generally, social and economic determinants of health have to do with money but also with belief systems. For example, in some developed countries such as Hong Kong, disability and mental health are greatly stigmatised, resulting in people hiding or seeking care outside the country.

Health tourism could be viewed as a benefit to host countries and consumers in many ways. First and foremost, health tourism can be very financially rewarding for less-developed countries. In 2006, the medical tourism industry grossed about US$60 billion worldwide, and it is estimated to reach US$100 billion by 2012 (Herrick, 2007). As a major draw for and benefit to consumers, prices for treatment are lower in foreign hospitals, for a number of reasons, including lower labor costs; third parties (insurance and government) being uninvolved or less involved; increased price transparency with package pricing; fewer attempts to shift the cost of charity care to paying patients; fewer regulations limiting collaborative arrangements between healthcare facilities and physicians; and lower litigation costs (Herrick, 2007). However, health tourism often comes at a cost for the local population and creates issues of staff poaching. For example, in Thailand, the resources used to service one foreigner may be equivalent to those used to service four or five local Thai patients, which can result in lack of services provided to local patients (Labonte et al., 2010). Some countries (e.g. Thailand, India, Philippines,

South Korea) are building private high-end hospitals partially staffed with medical personnel, particularly nurses, from more wealthy countries to cater to health tourism (Labonte et al., 2010).

Another issue is that medical tourism is often related to new technologies, moral values, or controversial treatments, such as end of life options, stem cell transplants, surrogacy or the international organ trade. For example, the most common form of international organ trade is 'transplant tourism', where potential recipients travel abroad to undergo an organ transplant. Several websites offer all-inclusive 'transplant packages' for a variety of organs, including liver, kidney, heart, and pancreas (Shimazono, 2007). These, like many other global health issues, are a consequence of global inequities and can be categorised as human rights issues. Social workers need to work with other professions and non-governmental organisations on health issues that can be characterised as human rights issues and advocate against inequalities in health and health practices (IFSW, 2005).

As social workers, it is important to advocate for equality in access to healthcare regardless of income or ability to seek treatment outside one's own country. The long-term implications of this new trend in global healthcare for health service delivery to local patients, staffing of medical services, quality of care and social work roles are yet to be fully understood. Additionally, the effects of healthcare tourism on the healthcare industry in tourists' countries of origin have yet to be fully studied, and may have unknown consequences in care available. Staff poaching is taking place across health and related fields resulting in staff shortages, including of social workers, in many countries, not least those of the global south (IFSW, 2008). The lack of social workers has significant implications for provision of services and care for the most vulnerable populations. Front line social professionals in UN organisations and INGOs are regularly confronted with these issues often without the financial resources and institutional capacity necessary to address them at an international level.

Providers

The past several decades have seen radical changes in economic paradigms, promoting deregulation of developing countries' markets and new international agreements on international trade and finances, which have contributed to inconsistent outcomes in global health status and had significant implications for the provision of social work services. Two examples of global trade agreements that have direct health effects are the General Agreement on Trade in Services (GATS) and the Agreement on Trade Related Intellectual Property Rights (TRIPS). TRIPS introduced global minimum standards for the protection of patents, trademarks, copyrights and other intellectual property rights. The main impact of this agreement has been to increase drug prices in countries introducing drug patents and restricting the possibility of producing or importing essential drugs in developing countries (Labonte et al., 2010). Due to the risks involved in new trade agreements such as TRIPS, the World Health Assembly in May 1999 mandated WHO to monitor the health consequences of international trade agreements (Cornia, 2001).

These global economic changes have sparked profound alterations in the actors that exert influence in global health as well as the roles and norms within these global health systems. Traditional players in global health, such as the WHO, are now being joined and/or challenged by a variety of UN organisations, INGOs, low and middle income national governments, private firms, and private philanthropists (Szlezak, et al., 2010). This increase in health providers, policy makers, and lobbying bodies creates new challenges regarding the roles and norms of various stakeholders. Moon and colleagues (2010) argue that a successful global health system in the current economic climate must undertake five core functions: agenda-setting;

financing and resource allocation; research and development; implementation and delivery; and monitoring, evaluation, and learning. They further contend that global partnership is essential to the success of an effective global health system and that no single stakeholder can or should set the agenda for action. However, for an efficient global health system, these stakeholders must strive to work in concert. Lessons from the fight against HIV/AIDS and malaria are two examples of the importance of global partnerships and the importance of taking into account the cultural and political climate of local communities and health systems (Moon, et al., 2010; Keusch, et al., 2010). In order to be successful in future health endeavours, global health systems must devise mechanisms for finding and targeting health consumers who suffer from specific illnesses; partners who contribute to research and development; and health practitioners and organisations that ultimately deliver interventions (Keusch, 2010). It is essential that long-term investments in education and training are provided at multiple levels to ensure the success of global health systems (Frenk, 2010; Moon, et al., 2010).

These global trends affect access to frontline social work services around the globe, particularly personnel working in UN organisations and INGOs. The IFSW (2008) argues that the right to social services is an inseparable part of health and healthcare along with interventions in formal medical settings. Social workers need to advocate for the social understanding of health and the roles social work can play in working for better health for individuals, families, communities and populations. There is a substantial gap in the availability of frontline social work services to meet individual and collective needs across the range of community, clinic and hospital settings, resulting in many individuals and families being unable to access social work services (IFSW, 2008). A core objective of IFSW policy is to extend the availability of social work health services across the range of work settings, but this requires a

commitment to train and resource frontline social workers. As globalisation continues to impact people's access to healthcare and health outcomes, social workers need to engage more effectively at a policy level with international institutions with responsibilities for influencing healthcare and/or with non-governmental organisations working for health related development (IFSW, 2008).

Activism

Over the past several decades, there have been significant changes in the role of consumers and advocates in the healthcare arena. A variety of movements across the globe (e.g. People's Health Movement and survivor/service user movements, consumer empowerment movements) have fostered the ability of consumers to take an active role in decisions and policies related to their health issues and the delivery of health services. An example of this trend is provided by the disability rights movement.

Before the development of the International Classification of Impairment, Disability and Handicap (ICIDH) there was no international organised disability rights movement (WHO, 2001). In fact, it was not until the 1980s that people with disabilities united in a recognised international force. Initially, scholars noted that the ICIDH model of impairment was the fundamental cause of the segregation of disabled people into institutions, inaccessible homes, and separate communities. People with disabilities also realised that 'unless they could live fully participating lives, their innate humanity – and the rights that pertain to that humanity – would never be recognised' (Hurst, 2003: 573). As a result, over the next several years, during the writing of the *International Classification of Function, Disability and Health* (ICF) (WHO, 2001), the rights of people with disabilities moved to the forefront of public debate. People with disabilities argued that disability is the outcome of environmental barriers and

attitudes that discriminate against people with impairments (Hahn, 1985; Hurst, 2003).

However, the ICIDH had a lasting negative effect on the rights of such people because it perpetuated the idea that able-bodied people were normal while people with disabilities were not. This idea amplified the concept of disability, equating it with incapacity, impairment, and a lack of functioning (Hurst, 2003). As a result (during the revision of the ICIDH to the ICF) disability rights advocates proposed a social model of disability that identified the environment and its inherent barriers as causes of disability. With the new revisions introduced in 2001, the ICF has moved away from simply noting the consequences of disease and disablement to classifying components of health rather than impairment. This represented a change from labelling individuals by 'disability', 'impairments', and 'handicaps' to more neutral or positive terms, such as 'body functions and structures', 'activity', and 'participation'. Additionally, the ICF was created to measure more than the diagnosed condition by also including the consequences of the condition. The ICF (WHO, 2001) describes disability as the intersection between the biological body and the social and institutional structures surrounding it (Hurst, 2003; Imrie, 2004; Ueda and Okawa, 2003).

While the ICF embraces a model of empowering the minority group, the healthcare systems of many countries continue to operate under the bio-medical models of disease and disorder definition. Social workers who embrace or practice in a bio-medical model may find it difficult to view individuals with physical disabilities as healthy, self-determined beings. The social model, shifting attention away from the functional limitation of a person, focuses on the social environments that impose restrictions upon people with disabilities (Fine and Asch, 1988; Hahn, 1985) and mirrors social work ethical principles of social justice and service. Social workers are expected to address social problems and injustices and to pursue social change on behalf of vulnerable and oppressed people. Empowerment social work embraces the social justice contract between individuals and society. It is incumbent on social workers to emphasise empowerment objectives rather than mere compliance with medically prescribed treatment plans or psychosocial clinical interventions (Beaulaurier and Taylor, 2001).

CONCLUSION

What will the future look like for international health social work? We have argued that health is a central battle ground for global policy making. International economic, social, environmental and political arrangements affecting income and wealth, food, water, employment and living conditions impact profoundly on people's health and the provision of healthcare is increasingly a globalised industry with overlapping elements affecting health insurance and other payments systems, health and social care services, pharmaceuticals and technology, staffing and regulation. Powerful tensions exist between liberalising economic forces on the one hand and the movements for human rights, social justice and user empowerment on the other.

Social work's international bodies have clearly aligned themselves with the latter of these two approaches but are in a weak position to influence developments in an unequal world. Practitioners will be increasingly affected by global forces influencing who they serve, who employs them, how they are trained and what they do. In this context, there is a continuing need to:

- develop the research base to underpin social work education and practice for health;
- articulate and make the case for social work's contribution to people's health and to reducing health inequity;
- make alliances with those professionals and activists who share common aims and values.

These three objectives can be enacted whereever social workers operate: on the front line of practice, in inter-professional and policy making forums within countries and where opportunities present themselves for international action.

NOTES

1   Different approaches to the possible content of a chapter about social work and health in a global context reflect varied perspectives on the notion of international social work. Other authors have chosen to compare and contrast the different forms which medical or health-related social work takes in different countries (Heinonen and Metteri 2005; Berkman and D'Ambruoso, 2006). We have chosen rather to focus on a major aspect of healthcare – inequalities related in part to processes of globalisation – and some of the concomitant challenges and opportunities facing social workers, internationally, whether they specialise in health social work or in the course of their daily practice.

2   The Commission on the Social Determinants of Health (CSDH, 2008: Preface) defines health inequity as 'avoidable health inequalities (which) arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces'.

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