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Revising social work's international policy statement on health: process, outcomes and implications.

Paul Bywaters and Lindsey Napier

Abstract

This paper presents the new IFSW policy statement on Health. In addition to describing the consultation process undertaken, it identifies the core content and background analysis informing it. Issues raised include the relationship between local practices of social work and processes of globalisation. Implications for future social work policy development are discussed.

Key words

Social work; international health; inequalities; health policy; globalisation.

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Globalisation is arguably making social work's international organisations increasingly significant. The neo-liberal forms of globalisation which have been dominant in the past twenty to thirty years are having a profound and multidimensional impact on the people and communities with which social workers engage. Processes of globalisation, while having positive aspects, have been associated with exacerbated social and economic inequalities, threats to health, education, social and other public services, rapid shifts in employment patterns contributing to mass migration (including movements of social workers) and intense pressures on the physical environment and climate (Labonte and Schrecker 2007). While most social work action is locally focused, the profession's commitment to social justice requires that it also addresses the global context in which practice takes place, attempting to influence that context, where possible, and to understand the connections between global processes and everyday lives (Payne and Aga Askeland 2008).

The two main international representative organisations in social work are the International Federation of Social Workers (IFSW) (<http://www.ifsw.org/en/f38000041.html>) whose voting members are national organisations of social workers (84 members at August 2008) and the International Association of Schools of Social Work (IASSW) which is 'the worldwide association of schools of social work, other tertiary level social work educational programmes, and social work educators' (<http://www.iassw-aiets.org>). These two bodies operate separately and together in both national and international arenas through their member national organisations and universities, and as non-governmental organisations with direct representation at the UN and in alliance with others through the International

Council of Social Welfare (ICSW). They provide a lead to social work internationally, for example, by working to establish core global standards for social work (Sewpaul 2005) and (in the case of IFSW) by producing policy papers (<http://www.ifsw.org/en/f38000033.html>).

This article is a reflection on the production of a revised IFSW policy statement on 'Health' (<http://www.ifsw.org/en/p38000081.html>), which was led by the authors. The policy revision was commissioned from the Social Work and Health Inequalities Network¹ (SWHIN) in 2006 and ratified at the IFSW General Meeting in Salvador, Brazil in 2008. The argument here falls into three main elements. First, we discuss the processes of development through which the policy was produced. Second, we briefly outline the core content of the statement and the key principles that informed it. Finally, the article considers what lessons can be learnt for social work in a globalised world.

Process

The responsibility for IFSW policy papers lies with its Policy, Advisory and Representation Commission (PARC) established in 2006. This recently formed body has been undertaking a programme to review and revise existing policies and to establish work to produce new policies where required. It has also prepared guidelines for the production of policy papers to try to introduce greater uniformity of style and approach. These state that a policy statement should be a declaration of IFSW's position, it should be durable, affect the breadth of the profession and be specifically relevant to it. More controversially, perhaps, the guidance also separates policy statements from implementation and makes it clear that a statement is not a practice

guide. Policy statements cannot commit IFSW to any specific actions or programmes or to the investment of any specific resources. This guidance will be returned to later.

The process by which policy statements are produced and acted on is less clearly established. In the case of the Health policy, the initiative for rewriting it came from SWHIN. In other examples of developing policies also discussed in Brazil, the initiative came either from PARC who identified one or more people with expertise to take the lead, or from individuals with a particular policy concern. There is no core funding to support the preparation of policies although some practical support is given by the IFSW Secretariat and a significant sum of money was spent on translation in the process of production of the policy on Health.

For SWHIN, revising the health policy was an activity which was designed to engage the wider membership but it was also felt that extensive consultation beyond the Network was the only appropriate way to proceed. We devised a three stage consultation process designed to promote a bottom up approach. The first stage involved the circulation of a questionnaire which asked respondents to consider definitions of health and core underlying principles, to identify key health issues in their experience and to indicate what kinds of action they would like to see social work organisations taking. This was circulated to three groups: the national organisations which comprise IFSW; individual members of SWHIN (around 150); and all those social work practitioners, managers, educators and researchers who attended the Social Work in Health and Mental Health conference in Hong Kong 2006. This last group – over 1500 people – was the largest database of social workers with a specialist interest in health that we knew of. This first consultation took place

by email over the winter of 2006/spring of 2007 and the responses were collated and analysed by summer 2007.

The second stage was the production and circulation of a draft policy statement. This was undertaken by the authors of this article, one from Australia and one from Britain, in the autumn of 2007. A 14 page version was circulated to the national member organisations of IFSW, plus individual members of PARC and of SWHIN.

A significantly revised and reduced version was produced for a final round of consultation with PARC and SWHIN members only. Very little further amendment was required before the General Meeting in Salvador which approved the policy unanimously with only one minor change.

While this consultation process was intended to be comprehensive and thorough, it was greatly weakened by the limited response rate, especially from IFSW member organisations and Hong Kong conference attenders. Five national organisations responded to the initial consultation and seven to the draft policy. Of these two countries responded to both stages, so 10 country organisations in total participated in the process at some stage. The second stage, in which documents were translated into French and Spanish, produced responses from France, Spain and Switzerland, but all responses in both stages were from developed countries, with 7 from Europe, and two from North America. This is clearly unsatisfactory both in terms of the proportion of country organisations engaging in the policy development process and the skewed nature of the countries that responded.

In addition, twelve completed stage one questionnaires were received from individuals: four from researchers, five from educators, two from managers and only one from a practitioner, seven of whom were members of SWHIN. At the second stage, responses were received from 11 members of SWHIN, all social work academics. While these included a small number of respondents from developing countries, again the range could not be said to be in any way representative of the experience of the three quarters of a million social workers represented by IFSW worldwide.

A further weakness of the process was the lack of consultation with ‘clients’ or ‘service users’. We asked national organisations responding to the questionnaire to let us know whether service users had been consulted in the preparation of responses. None had been involved, with one country indicating that it lacked the resources for such a consultation. Another wrote, ‘including the clients in fact-finding actions and research is limited by two factors: The social worker/client interactions are covered by the (national association’s) Code of Ethics and a (...) Government provision for the protection of subjects in research. Thus, asking clients to fill out the questionnaire is not easily accomplished. However, social workers, who work directly with clients in their practice, know what their clients think about health care and other related issues.’

We have been told that this was the most extensive consultation process ever undertaken in the production of an IFSW policy statement. However, from our point of view this was a disappointingly low response rate which reduced our capacity to write a representative global policy. In the absence of a deeper analysis it is hard to be at all certain about the reasons for this. Potential respondents were given a substantial

period of time to respond and none raised time scales as a problem. There may have been language barriers, as translation was only into two non-English languages and only at one stage in the process. The low response might reflect the limited resources available to many national organisations of social workers.

While resources may well have been an obstacle, the level of response also suggests a problem of engagement or commitment which seriously weakens the capacity of IFSW not only to produce effective and widely supported policies but also to act on them once produced. Given the low response to consultation, we are bound to wonder whether the policy will be effectively disseminated by national organisations, let alone acted on as a basis for policy advocacy. Again, the issues of dissemination and action are not covered in the IFSW Guidelines for policy production. These arguments are not advanced in order to criticise colleagues in the organisations concerned but because they raises questions for all social workers about how to secure effective international representation and advocacy on issues of concern to the profession. Is participation in policy development, dissemination and implementation a matter of professional responsibility and, if so, how can we create effective processes?

Content

The content of the policy was founded on the lead authors' knowledge and analysis of academic, policy, experiential and practice literatures about (physical and mental) health and illness which informed the consultation processes. Here there is only room for the briefest of outlines and we hope readers will consult the full text (<http://www.ifsw.org/en/p38000081.html>). We drew particularly heavily on two key

contemporaneous pieces of work also analysing global health policy: one from a professional context and one from a social movement. In practice, the analysis underlying these two reports had much in common with each other and with the views expressed through the consultation processes.

Over the same period that we were developing the IFSW policy the World Health Organisation's Commission on the Social Determinants of Health (CSDH) was undertaking a much larger scale task to produce an international policy response to the 'Dramatic inequalities (that) dominate global health today' (CSDH 2007: 2). Interestingly seeing itself as not just producing a report but building a 'global movement for change' (ibid), the Commission established nine Knowledge Networks which also produced a series of reports and analyses on which we were able to draw. It also sought to engage both with civil society organisations and with the worldwide social movements in health. One of the Commissioners (Fran Baum) is a Co-Chair of the Global Coordinating Council of the People's Health Movement.

The People's Health Movement was also a key player in the production of our second core source: the report Global Health Watch 2005-6 (Global Health Watch (GHW) 2005). GHW is a broad collaboration of public health experts, non-governmental organisations, civil society activists, community groups, health workers and academics which came together to produce a series of alternative health reports. It was initiated by the People's Health Movement, the Global Equity Gauge Alliance and Medact. This collaboration sees itself as providing an alternative critical perspective to that presented by the official international institutions such as the WHO and the World Bank.

The final report of the World Health Organisation's Commission on the Social Determinants of Health (CSDH 2008: Preface), published after the IFSW Health policy was agreed, opens by saying that, 'Social justice is a matter of life and death.' This statement locates health policy in two key ways: as a social issue rather than a biological or medical one, and as an issue of human values or ethics. For us too, the revised health policy had to be rooted in the social perspective which underpins social work practice and in the emphasis on human rights and social justice which is central to the joint IFSW/IASSW Statement of Principles for Ethics in Social Work (<http://www.ifsw.org/en/p38000324.html> accessed September 2008). This ties in closely with the widely known holistic definition of health enshrined in the WHO Constitution, with its accompanying assertion 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' (http://www.who.int/governance/eb/who_constitution_en.pdf). Despite some well known reservations about the WHO definition (for example, Saracci, 1997), its holistic approach which treats physical and mental health as interconnected was universally supported by national respondents as the basis for the policy statement.

As in the CSDH (2008) report, for us, the second step in the argument was that the gap between these aspirational statements about the right to health and the realities for billions of people worldwide is unjust and unacceptable. Asserting that health is a fundamental human right implies a commitment to health equity: 'the absence of disparities in health (and in its key social determinants) that are systematically associated with social advantage/disadvantage' (Braveman and Gruskin 2003).

However, measures of mortality and morbidity show immense and often growing socially created inequalities in health within and between nations (CSDH 2008). Average life expectancy in several Sub-Saharan African countries is less than half that in several of the richest nations and in some cases life expectancy has dropped substantially in the last twenty years as a result of a combination of factors. But within country inequalities, consequent on social and economic status, are also often massive between social classes, between men and women and between majority and minority populations, including indigenous peoples. Moreover, not only are the determinants of health unjustly distributed but also opportunities for health care. For hundreds of millions of people living in poverty, even basic health care is unattainable because of lack of income. For others, the cost of securing health care is the factor which pushes them into health destructive poverty (GHW 2005).

The explanations for these unacceptable difference lie in social, economic, political and environmental factors and hence, crucially, are linked to the particular forms of neo-liberal globalisation which have been dominant in the past twenty to thirty years (GHW 2005; Labonte and Schrecker 2007). These have had a variety of impacts on the distribution of the conditions for health and on health and other services to prevent and treat illness and provide care for people when ill. In the policy we outline ways in which neo-liberal globalisation, sometimes enforced through international institutions such as the World Bank, and reinforced in negotiations about, for example, trade, the environment and intellectual property rights has resulted in economic instability, reduced levels of social protection, unfair trade conditions, the privatisation of health related public services, the commodification of bodies, health and health care, environmental destruction and climate change, and violence and insecurity.

The final focus of the statement is on the relationship of social work to this analysis. Our view is that social work *is* health work. As we write in the policy, social workers in all settings engage every day with children, men and women struggling to realise their basic rights to health. It is not only social workers in health settings such as hospitals or clinics who must be concerned with health issues. There are two basic reasons for seeing health as a central dimension of social work. First, it is because health is primarily a product of social determinants such as food, water, income, housing, a safe environment or education, so helping people secure essential resources for everyday life and human development is health work. Second, it is because health is central to people's lives. Most health promotion, prevention, treatment and care is carried out informally by people looking after themselves and their families and friends. Maintaining health is a key human objective across the lifecourse and having a voice in decision making about health (at individual and policy levels) is a right. Social workers should view themselves as co-workers with individuals and communities, as they seek to secure the resources, including social services, which underpin health and enable them to manage illness.

But this analysis, with its emphasis on the global also makes it obvious that social work has to engage at a national and international level with policy issues affecting health. Again this means more than policies about health *care*, although issues such as equity of universal, affordable access to primary and specialist health services are a vital concern throughout the world, including in the world's richest and most powerful nations. Policies affecting the conditions for health, including regulating the global market, should also be a concern for social work. This entails creating alliances

with others with whom we share common objectives, in order to operate more effectively in international policy making forums.

Reflection

Despite the limited level of engagement with the consultations, a central experience of the process of developing and ratifying the Health policy was the surprising degree of unanimity amongst the 35 responses. For example, in one author's (Bywaters) experience of the UK, the idea that health is a central focus of social work in all settings is not reflected in either the curricula of social work qualifying courses nor in the dominant discourse of social work research and theoretical development. With exceptions, physical health has had a limited purchase in UK social work education since the 1980s. Moreover, an holistic perspective on health has been undermined by the development of strands of thinking and practice which were built around distancing rights based approaches to mental health and disability from medicalised approaches to physical health and illness. This is apparent in Thompson and Thompson's recent (2008) core student text which, in selecting over 100 'key terms and concepts', does not mention physical health or illness or health inequalities. Similarly a focus on anti-discriminatory practice in the UK has focused attention away from an analysis of or opposition to growing social inequalities. Perhaps the unanimous approval of the health policy by national organisations suggests that the UK is now out of step with international conceptions of social work.

A second surprise was the absence of concern amongst our international respondents to make a more central issue of the relationship between social work and other health professions, although one respondent did want us to give greater centrality in the

analysis to medical advances. As one of us has discussed previously (Bywaters 1986; 1989), this concern has been a longstanding focus of attention in social work writing about health related practice. In many health settings, the distribution of power between professions and through the managerial hierarchies is still a major focus of interest (Reece and Sontag 2001; Lymbery 2005). However, the response to our consultations and to the final document suggests that social work is now no longer defining its health role by contrast with or through seeking collaboration with other professions but by asserting its own standpoint as a basis for conditional alliances.

However, this degree of common purpose will not necessarily result in concerted action as it is not clear that the bodies which currently represent social work worldwide have the resources or the support to make an impact. IFSW has a tiny central staff, and a total annual operating budget of less than £250,000. The Policy Commission of IFSW is largely reliant on the voluntary activities of a small number of individuals without substantial professional input. Similarly the role of representing IFSW at a global level falls on a small number of individuals mostly working on a voluntary basis. IFSW also has no power to instruct or require national organisations of social workers to take any particular action. It relies on the goodwill and the capacity of national bodies to take up issues raised, national bodies which may themselves have difficulty in galvanising action by grassroots social workers. Against this background, it is not surprising that the guidelines for policy development are so concerned that IFSW should not be committed to any specific action or expenditure. There is not currently the capacity for substantive action.

This is stated as a challenge for the profession as a whole rather than a criticism of the individuals who are giving extensively of their time and energies to the existing structures. There are perhaps two alternative but not incompatible directions for taking up this challenge. One approach would be through building a much more robust set of representative social work institutions with the resources to engage in the medium to long term processes required to build alliances and establish an influential presence in key policy locations. The alternative approach would be through social workers engaging as activists in social movements.

In the health field, there are very interesting examples of social movements which are attempting to shift global agendas in directions which social work would support. For example, the objectives of the People's Health Movement are:

- *To promote the Health for All goal through an equitable, participatory and inter-sectoral movement and as a Rights Issue.*
- *To encourage government and other health agencies to ensure universal access to quality health care, education and social services according to people's needs and not people's ability to pay.*
- *To promote the participation of people and people's organisations in the formulation, implementation and evaluation of all health and social policies and programmes.*
- *To promote health along with equity and sustainable development as top priorities in local, national and international policymaking.*
- *To encourage people to develop their own solutions to local health problems.*
- *To hold accountable local authorities, national governments, international organisations and corporations. (<http://www.phmovement.org/cms/en/about>)*

This process of holding to account local, national and international governing institutions based on a rights perspective is reflected in the approach being taken to the development of a universal, publicly funded health system in Brazil, the Sistema Unico de Saude. As Cornwall and Shankland (2008) outline, health has been a key site for the struggle for democratisation in Brazil with a series of National Health Conferences and local health councils, engaging hundreds of thousands of people, seeking to establish the direction of national and local health services and to hold politicians and officials to account. Cornwall and Shankland point to the importance of the Brazilian model of participation operating through collective processes of discussion and debate rather than through individualised consultations with patients as consumers.

The Brazilian health service has a long way to go to make the universal rights to health and to health care that are enshrined in legislation into a reality. And the political context in which this model of engagement is being developed is particular to the Brazilian context. Nevertheless, it may be that the actions of social workers who directly engage as fellow citizens in movements for health and through informal Networks such as SWHIN will have greater impact than the laborious process of building stronger international representative institutions for social work. If social work fails to articulate effective ways of relating to processes of globalisation it will increasingly fail to be able to act on its ethical commitment to social justice and human rights.

Notes

1. The Social Work and Health Inequalities Network is an international network of social workers which 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. For more information see www.warwick.ac.uk/go/swhin.

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