

Reducing health inequalities: what place for social work and social care research?

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Introduction

This paper outlines how social work and care research can contribute to the core Department of Health policy focus on health inequalities. In part one I sketch out the bones of that policy strand, using the key arguments which inform the Commission on the Social Determinants of Health. I suggest both that social care can gain from a parallel application of a social determinants framework and that a health inequalities lens reveals the central but largely unrecognised role of poor health in social care provision. In part two, I give a number of examples of the ways in which social work and care research, despite a critical, long term shortage of resources, is already contributing to health inequalities policy, particularly through studies of social care interventions. In part three, I suggest some ways in which social work and social care research could develop to maximise social care's contribution to tackling inequalities in health.

Part 1: Social work, social care and health inequalities policy

1. HIs: a Core Policy Priority

- 1.1 Reducing health inequalities has been a core health priority for this government since 1997. From the setting up of the Acheson Inquiry (DH 1998a) within weeks of the 1997 election and the 1998 White Paper, Our Healthier Nation (DH 1998b), through the 2003 Tackling Health Inequalities Programme of Action (DH 2003), the DH Strategic Framework (2008a) to the recent establishment of the Marmot Commission on Health Inequalities, the UK Labour government has given unprecedented priority to cutting inequalities in health. It has become recognised as a world leader in this policy area, and its commitment at Ministerial and Prime Ministerial levels was visible in the recent hosting of an international conference to publicise and discuss the findings of the WHO (2008) Commission on the Social Determinants of Health (CSDH).
- 1.2 I want to take the CSDH analysis as a starting set of assumptions, essentially shared, I believe, by government and which powerfully echo the International Federation of Social Workers' policy on health (<http://www.ifsw.org/en/p38000081.html>). In his presentation to the November conference, Sir Michael Marmot emphasised 3 core points:
 - tackling inequalities in health is fundamentally a moral issue, an issue of social justice;
 - empowerment has to be central; material, psychosocial and political empowerment. This means ensuring that people have the resources for health and for healthy behaviours; that they have control over their lives and choices; and that they have a voice in services and policies.
 - that to reduce health inequalities we have to improve the basic conditions in which people live their daily lives, at every stage across the lifecourse. This means changing the structural drivers that affect those conditions;

monitoring interventions, researching effectiveness and training practitioners, commissioners and policy makers in what works.

- 1.3 Effective action on the social causes of health inequalities, the causes of the causes, would radically improve the quality of life of most social care service users, and underpin the capacity of social care services to meet people's personal needs. As the Foreword to Tackling Health Inequalities: 2007 Status Report on the Programme for Action (DH 2008c, p3) has it: 'The potential benefits are legion if we succeed in narrowing the health gap. It offers the prospect of improvements in social, economic and environmental terms as well as in health terms for individuals and their families.'

2. Social Care and Health Inequalities Policy

- 2.1 I would argue that this health inequalities perspective underlines both
- the relevance of social care to central themes of health policy and
 - that social care work is health work.
- 2.2 The 1998 'Our Healthier Nation' White Paper said:
High quality social services play a vital role in the health of the people they serve. Decent support for older people, whether at home or in residential care, the protection and care of vulnerable children and young people; support for people with mental health problems; and helping people with disabilities live more independent lives; **health and social care are often one and the same.** (DH 1998b, p23.)
- 2.3 But somewhere along the way, this crucial perspective has been lost. First, social care has become marginalised in discussions of health inequalities. In the 2003 paper, 'Tackling Health Inequalities: Programme for Action', social care was only mentioned in 4 of 82 action points, and in those four points always tagged onto health. Second, equally importantly, current discourse about social care almost ignores the social determinants: the Case for Change (DH 2008a) document makes one use of the words 'inequality' or 'inequalities', buried deep on page 46 out of 56 and the DH Strategic Framework (DH 2008b) highlights inequalities in its review of progress in the NHS, but not in reviewing social care. Somehow, policy discussion of social care has become detached from social determinants.

3. Common Social Determinants

- 3.1 The vast majority of social care services (and I am including children's as well as adult services here) provided or purchased through the public sector (as against those arranged entirely privately) are provided to people who are profoundly socially disadvantaged (McLeod and Bywaters 2000). The large majority live in poverty, often long term poverty, with accompanying poor environmental conditions and attenuated social resources. Many additionally face stigma or discrimination because of their social circumstances or identity. Almost every service user is, therefore, either:
- someone whose future health is threatened by the conditions in which they live - children and young people being brought up in poverty and typically facing multiple problems in securing the basis for a health life: good food,

- or someone who is already suffering from some form of physical and/or emotional ill health which is impacting on their daily life (working age adults and older people with chronic physical or mental illnesses) and who is lacking the financial and social resources to manage without public services.

While tackling health inequalities requires action across the whole of society, if you wanted to find target groups for remedial action on health inequalities, social care service users across the lifecourse could provide an obvious starting place.

- 3.2 Because tackling health inequalities requires addressing the social, economic, environmental and political conditions which affect health and not just focusing on illness or on health services, this is relevant to social work and social care in all settings, not just to social workers in hospital, in mental health teams, or working with alcohol and drug users.

4. Changing Mindsets

- 4.1 This perspective, that social care work is health work, challenges social work and social care staff to think differently about themselves and to practice differently: to think of themselves as health workers and for services to be re-oriented accordingly. An MPhil student of mine examined a small set of social care files of older people who had been assessed as having high priority for receiving services. In the large majority of those files, the service users' illnesses were not recorded, there was no evidence of discussion about how their ill health was being managed or evidence of discussion with health staff. The illnesses which were at the heart of the social care assessment were simply an uninterrogated backdrop to decisions about provision.
- 4.2 It is a challenge for social care researchers in terms of both focus and methodology.
- 4.3 It is a challenge for the health world:
- to recognise more fully that what social work and social care staff do can contribute to improving population health by addressing health inequalities
 - to examine the implications for commissioning social care interventions
 - and to fund health related research into the impact of social care interventions on health inequalities.

Part 2: Evidence of Social Work and Social Care Impact on Health Inequalities

5. Social Care Research Contribution

- 5.1 Nationally and internationally, research evidence about the impact of social work and social care on health inequalities has been limited by the relative lack of resources available for social work research (Bywaters and Ungar, forthcoming). Marsh and Fisher (2005) calculated that the level of research funding per staff member was over hundred times less for social care than for health.

- 5.2 However, social work and social care research is already contributing both
- a better understanding of health inequalities and the mechanisms by which relatively disadvantaged social conditions translate into poor health outcomes;
 - to testing the evidence for the impact of social care interventions on inequalities in health.
- 5.3 In the future, in addition to the two roles outlined above, social work and social care research could also contribute to health inequality policy through
- a better understanding of the impact of policies designed to reduce health inequalities on particular populations of social care users.
- 5.4 I want to focus mainly on evidence of the impact of social care interventions, but just one example of social work research contributing to better understanding of how health is put at risk by disadvantaged social conditions comes from the work of Professor Ravinder Barn and colleagues examining the lives of care leavers from minority ethnic groups, building on earlier work by Professor Bob Broad and colleagues. In 2005, Barn et al detailed the absence of the basic resources for health: money, work, food, shelter, education, stable relationships and the frequent presence of health damaging behaviours and experiences for such care leavers: racial discrimination, substance misuse, teenage pregnancy and young parenthood, sexual abuse and risk, crime as victim and perpetrator. In 2007, Barn and Mantovani reported on the relationship between the exposure to poor social conditions and unhealthy behaviours for young women in the care system, and the risk of early pregnancy and poor mental health.
- 5.5 Turning to the impact of social care interventions, I can only choose a small number of examples to illustrate how social care research can address primary, secondary and tertiary levels of the tackling health inequalities policy agenda.

6. Primary Prevention: equalising the conditions for health

- 6.1 A key issue in delivering services locally to equalise health chances is the difficulty in reaching and engaging the most disadvantaged. This is important if service provision is not to further increase gaps between more or less disadvantaged. Social care services have the potential to play an important role of connecting the hardest to reach groups to a range of resources and services. However, this model has not been adopted systematically and research can only be indicative.
- 6.2 **Poverty:** While local authority social work and social care services nowadays focus less directly on anti-poverty work than was the case in the past, Drakeford, in Wales, has reported on research into a number of policy initiatives which shows how social workers can be instrumental in linking individuals and families living on the margins of society, the most socially excluded, with locally based anti-poverty programmes (Drakeford 2006; McLeod et al 2007; Drakeford and Gregory 2008). However, the extent and effectiveness of such social work practice is unknown while it is clear that inequalities in service provision are being exacerbated by the inconsistent approach to the role of social

workers in anti-poverty work in different children's and or adult services departments.

- 6.3 Stigma: A second example, from the mental health field, is social work involvement in the 'Mosaics of Meaning' project, Glasgow based action research aiming to reduce the stigma associated with mental health amongst people from minority ethnic communities, and thus enable people suffering from mental ill health both to secure better responses both from informal resources - their families and communities, employers etc. – and be more likely to seek help from formal health and social care services. The second stage of this project involved trialling a series of 'community conversations' about mental illness in partnerships between community organisations, academics and health and social care practitioners. These interventions have produced statistically significant evidence of changes to more positive attitudes to mental health (Glasgow Anti-Stigma Partnership 2007; Quinn and Knifton forthcoming).
- 6.4 Conditions for pre-school development. A third example is the work of Sure Start, now Children's Centres, in improving the health and life chances of disadvantaged families through multi-agency service provision for pre-school children. The recent report on the Impact of Sure Start local programmes on 3 year olds by NESS found evidence of significantly better outcomes for children in SSLP areas by comparison with children who had grown up in areas without Sure Start programmes in respect of 7 out of 14 outcomes and no negative effects (Melhuish et al 2008; National Evaluation of Sure Start, 2008). As with the Scottish and Welsh examples given earlier, social care was only one participant amongst a multi-agency programme. But the issue of connecting the most disadvantaged families – often those in contact with Children's Services - to the range of SSLP services available remains a key challenge (see Emerson et al 2009).

7.0 Secondary Prevention and Health Promotion: equalising access to health care

- 7.1 There is more direct evidence of mainstream social care interventions having an impact on the health chances of at-risk groups through secondary prevention. Social care staff often work with people facing multiple overlapping forms of health risk, such as unaccompanied child asylum seekers, disabled children and adults from minority ethnic groups, isolated young carers, or older people and their carers wrestling with physical and cognitive ill-health in situations of poverty. Two examples of research on interventions with such groups are:
- 7.2 Health outcomes for looked after children. A local authority project in Scotland was designed to radically improve health outcomes for children and young people in the care system. By adopting a population based rather than a case by case approach to the health of young people in care, it was possible to establish new service patterns which, partly through raising social workers' awareness of health issues, significantly increased the take up of dental and GP health checks. (Greaves and Mulholland 2006).
- 7.3 Health checks for people with learning disabilities. The Michael Report (Michael 2008) recommended that a systematic and proactive approach to providing health checks for people with learning disabilities should be adopted.

One such project was an intervention to provide routine access to health checks for service users accessed through a community learning disability team (Martin et al 1997). 83% of those who agreed to a health check had undetected health problems.

- 7.4 While neither health checks nor access to medical care are the primary ways of improving population health, this and other evidence supports the argument that similar population based approaches with other groups of service users who are sufferers from the ‘inverse care law’ would have similarly beneficial outcomes if social care staff awareness was appropriately heightened.

8.0 Tertiary Prevention: equalising the experience of ill-health

- 8.1 Social work and social care staff habitually work with people already suffering long term and severe ill-health. The winter pressures programme was based on the idea (and some evidence) that interventions which enhance the early identification of people with social care needs can make NHS facilities work more efficiently and effectively, better able to meet targets and to provide a service which service users prefer. Just one example will have to suffice here.
- 8.2 In a number of publications (Bywaters et al 2002; Bywaters and McLeod 2003; McLeod et al 2003, 2007, 2008; McLeod and Olsson 2006; Fisher et al 2008) Eileen McLeod from Warwick, myself, and colleagues, have reported on the role of social work and social care in A&E departments. International evidence suggests that locating social work services in A&E can have the effect of deflecting people from admission when social rather than medical needs predominate and that early referral to social work services can reduce hospital lengths of stay and facilitate discharge with enhanced resources for recovery and rehabilitation.
- 8.3 It is clear that in the UK there are considerable geographical inequalities in terms of whether A&E departments provide direct access to social care services. Our work suggests that around a third of A&E departments include such services and, where they do, the services offered, the times at which services are available and the role and skill mix varies hugely. Service users and carers report the benefits of social workers being based in A&E for the quality of their experience (including the quality of medical care) and NHS staff report the benefits of being able to secure rapid access to social workers for cases which are complex or ‘messy’ in purely medical terms and require time to sort personal and system issues. However, neither the effectiveness nor the costs of the multiple initiatives to provide direct access to social care through A&E, have been adequately researched. It is clear, however, that the patchwork approach to service development which has been adopted is likely to be improving the experience of some socially disadvantaged patients while increasing geographical inequalities of access to health and social care services.

Part 3: Directions for Future Research

9.0 Understanding Health Inequalities and Policies

- 9.1 **Social Epidemiology: service user populations and outcomes.** Several of the examples given above involve taking a population rather than a case by case

approach to intervention. But there is little history of social epidemiology in social work and social care research.

For example, we do not know much about:

- the adult health outcomes or life expectancy of people who have spent their childhoods in the care system
- what patterns of ill-health and social resources, or lack of them, result in needs for social care services and what forms of personal resources or social capital prevent the need for expensive services
- the health outcomes of intensive home care, or entry into sheltered accommodation or residential care amongst older people.

9.2 **A Lifecourse Perspective.** In terms of a better understanding of health inequalities and the impact of existing policies, a life course perspective suggests a series of populations of social care users who could be a focus of research:

- Pregnant teenagers and young parents
- Children, especially pre-school children, on child protection registers and their families
- Looked after children, including unaccompanied asylum seekers, and care leavers
- Young disabled people making the transition to adult support services
- Adults of working age, particularly disabled adults and those living with mental and physical ill-health, including terminal illness
- Older people, especially those with limited personal or social capital.

9.3 Such research could also incorporate three strengths of social work and social care research:

- Examining the cross cutting impact of diverse social identities: for example, ethnicity, gender and sexual orientation,
- Focusing on factors which contribute to resilience as well as to health damage
- Involving service users in research at all stages.

10.0 Testing Social Care Interventions

10.1 **Basic Descriptive Data: service provision.** Such is the low level from which such research is starting, there is a prior need for basic descriptive data. Since the 1980's we have not kept even basic descriptive data about what social work and social care services are being offered in health care settings, never mind adequately researched and costed analyses of the outcomes of social care service provision based in the NHS. Given the wide variations in provision, this is an issue not only of efficiency and effectiveness but of equity.

10.2 **The Health Impacts of Social Care.** Equally we know very little about the health impacts of community based social care services, for example, about whether access to social care services for people with illness or impairments results in more equal physical and mental health outcomes. So two research questions to be explored could be:

10.3 How can social care better support people who have experienced cumulative disadvantage to manage long term illness?

Can social care support be constructed in ways that support those who are at the bottom of the health inequalities gradient to improve their experience of living with physical and/or mental health, reduce deterioration, exercise control and enhance the social resources that mitigate the impact of poor health.

10.4 Can social care interventions make an effective contribution to equalising the material and social resources which both enable people to live independently and to maximise their health chances?

For example, what would be the impact of locating financial advice services in hospitals, at the point where serious illness can be the factor which overwhelms fragile social resources? Can the personalisation agenda be constructed in a way which does not benefit those most able to take control of their lives because of relative social advantage?

Conclusion

I believe there is a great deal of benefit to be gained for social care by rediscovering a focus both on the causes of demand for social care services for children and adults, the social determinants, and the centrality of poor and threatened health in services users' lives. This re-focusing would also increase the opportunity for social care to contribute significantly to a central strand of health policy: tackling health inequalities. Social work and social care research has already made a small contribution to health inequalities policy and practice but there is considerable scope for this contribution to be much more valuable, providing there is both a recognition of this potential and a substantial, long term investment of research resources.

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