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Health inequalities at the heart of the social work curriculum.

Author

Julie Fish, PhD

Reader in Social Work and Health Inequalities

Division of Social Work

De Montfort University

Leicester

Le1 9BH

Jfish@dmu.ac.uk

Co-author

Kate Karban

MA Mental Health Programme Director

Division of Social Work

University of Bradford

Bradford BD 7 1DP

Tel: 01274 233512

E Mail: k.karban@bradford.ac.uk

The authors are Joint convenors of the Social Work and Health Inequalities Network which is a network of over 300 social work academics and practitioners from 25 countries worldwide.

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Abstract

Efforts to reduce the widening gap between the health and social well-being of people within and between countries have become an urgent priority for politicians and policymakers. The Rio Declaration called on governments worldwide to promote and strengthen universal access to social services and to work in partnership to promote health equity and foster more inclusive societies. This paper contributes to international debates about the role of social work in promoting social justice by reducing social and health inequalities. Despite clear commitments to promote good health, there is a notable absence of a social determinants of health perspective in international social work curricula standards. The current review of social work education in England presents a timely opportunity to integrate such a perspective in teaching and learning and to disseminate this more widely. Employing the concepts of downstream and upstream interventions, the first part of the paper examines the distinctiveness of the social work contribution to this global agenda. In the second part of the paper, we consider how the content of learning activities about health inequalities can be incorporated in international social work curricula, namely, human rights, using gypsy and traveller families as an exemplar, inter-professional education and international perspectives.

Key words: social determinants of health; health inequalities; human rights; social justice.

Health inequalities at the heart of the social work curriculum.

Introduction

Worldwide there are stark differences between and within countries in the likelihood of a child dying before their fifth birthday or of an adult living a long and disability free life (Bywaters, 2009). Yet it is clear, from the experience in the UK, Australia and in Western Europe, where universal healthcare is free at the point of delivery, that the factors which lead to these differences in health outcomes do not primarily derive from variations in access to medical treatment (e.g. Townsend and Davidson, 1992). Rather they arise from the social conditions in which people live, work, grow and age. Poor housing, an inadequate diet, unemployment, poverty or impaired mobility have a negative impact upon people's health and their 'ability to live a flourishing life' (Marmot, 2010; 3). These differences in health experiences and health outcomes are widely known as health inequalities: they are distinctive from health concerns because they are unjust and amenable to social and political change.

Tackling health inequalities has been a global political concern since the 1978 Declaration of Alma Ata. In the intervening decades, the call for the attainment of the highest possible level of health as 'a most important worldwide social goal' (Declaration of Alma Ata, 1978) has remained an urgent health priority. Responding to concerns about persisting and widening inequalities, the World Health Organisation (WHO) established the Commission on Social Determinants of Health (CSDH) to produce a report on strategies to reduce them (CSDH, 2008). In 2011, the WHO convened a global conference which brought together Heads of Government, Ministers of Health and other stakeholders of 125 countries

worldwide to begin dialogue about ways of implementing the WHO recommendations. The resulting Rio Declaration which reiterated the determination to achieve 'social and health equity through action on the social determinants of health' was endorsed by the World Health Assembly in May 2012. Governments around the world have developed policies to realise the goal of health for all including in the US, *Healthy People 2020*; the UK, *Healthy Lives, Healthy People 2010*; South Australia, *The Adelaide Statement on Health in all Policies*, 2010; and in several countries in Western Europe (Hogstedt et al. 2008). In many of these policies, there is explicit recognition that the causes of health and well being 'lie outside the health sector and are socially and economically formed' (Adelaide Statement on Health in All Policies, 2010; 1). These social inequalities are collectively known as the social determinants of health and they include age, class, disability, gender, 'race', religion, sexual orientation and gender identity alongside adverse life experiences, such as homelessness, poverty, seeking asylum, being a child in public care, mental distress, domestic abuse and problematic drug use (c.f. Navarro, 2009; Wilkinson and Pickett, 2009; Marmot, 2010).

The recognition in *Fair Society, Healthy Lives,* the review of health inequalities in England that 'health inequalities result from social inequalities' (Marmot, 2010; 15) is not new: several UK government commissioned reports into health inequalities including the Black Report 1979; the Health Divide 1987 (Townsend and Davidson, 1992); the Acheson Report 1992; and the National Support Team for Health Inequalities 2008 (Bentley, 2008); acknowledged that social inequalities can lead to health inequalities. Moreover, of the 39 recommendations made by the Acheson Report in 1992, only three were 'directly related to improvements in healthcare' (Murty et al. 2009; 1404). Yet despite the centrality of social inequalities in determining health experiences and health outcomes, most of the

international policies (mentioned above) which aim to address health inequalities make little or no mention of social work or social care. For example, the South Australia implementation plan for *Health in All Policies* (Kickbusch and Buckett, 2010) fails to make a single reference to social work or social care. In a similar vein, of the 46 topics in the US *Healthy People 2020*, most are clinical health indicators, such as arthritis, osteoporosis, blood disorders and chronic disease. Despite the recent introduction of an indicator of 'health-related quality of life and well being', the policy fails to mention social work or social care. Moreover, when social work is discussed in policy, it is often within a narrow understanding of the range of work that social workers engage in. For example, *Fair Society, Healthy Lives* refers to social workers as frontline staff who 'lack political and popular support' (Marmot, 2010; 88) although their role in children's services is briefly acknowledged for families with 'complex material, social and health needs' (Marmot, 2010; 98); elsewhere, there is recognition that adult social care makes a 'significant contribution to tackling health and health inequalities' (Marmot, 2010; 159).

Healthy Lives, Healthy People 2010, the health inequalities policy for England locates the agenda for tackling health inequalities within public health (Department of Health, 2010; 4) and appears to overlook the central role that social work plays in this endeavour. Yet social work has a long tradition of working to mitigate the effects of poverty and social disadvantage. The origins of social work and social care can be found in the nineteenth century re-settlement movement led by Jane Addams in Chicago USA, and in the UK, in the work of social reformers, such as Octavia Hill, the work of the Charity Organisation Society and the Joseph Rowntree Foundation whose vision was to tackle the root causes of poverty and other social problems rather than treating their symptoms (Darley, 2010). The recently

adopted Global Agenda for Social Work reiterates the pledge of working for social justice

recognising that 'unjust...economic systems...have damaged the health and wellbeing of

peoples and communities causing poverty and growing inequality'; it espouses an explicit

commitment to 'positively address the root causes of oppression and inequality' (IFSW,

2012: 1). This commitment is also embedded in the newly introduced Professional

Capabilities Framework in England (College of Social Work, 2012) in 'Rights, justice and

economic wellbeing'. Internationally, social work has a long history of working alongside

groups who are among the most disadvantaged in society including homeless people,

asylum seekers and refugees, disabled and older people, children and young people, people

with mental health problems and people in poverty. As a discipline, social work has much to

contribute to the goal of reducing health inequalities: in its core values of anti-oppression, in

its frontline role of working among disadvantaged communities and neighbourhoods and in

its methods of work where it seeks to build on people's existing skills and networks to find

their own solutions in addition to providing financial, material or other resources to enable

them to do so. Thus social work is ideally placed to tackle:

> (The) 'link between social conditions and health (which) is not a footnote to the real
>
> concerns with health – health care and unhealthy behaviours – it should become the
>
> main focus' (Marmot, 2010; 3).

In practice, 'health' and 'social' needs are often understood as two separate and

oppositional components within a binary construction, relating to procedural or budgetary

systems, rather than as the conceptual framework adopted here, as inter-dependent

aspects of an understanding of well-being in which both are intrinsic and inextricably linked

(see Fook, 2002). In the following section, we consider how social work contributes, through downstream interventions, to an existing health agenda and then examine its role in the 'main focus' (Marmot, 2010; 3) of addressing social and health inequalities through upstream interventions.

Downstream and upstream interventions: The central role of social work in addressing health inequalities

Common terminology has emerged to describe efforts to tackle health inequalities, widely known as 'downstream' and 'upstream' interventions; however, the terms are often used without clarifying what factors they aim to address (e.g. Goodwin and Lawton-Smith, 2010). Downstream interventions are those which tackle the effects of inequality; within this approach, inequalities in health are characterised by a range of measures of death or ill-health; for example, by the rates of infant mortality in a geographical area, life expectancy, patterns of ill health including cardio-vascular disease and cancer; by access to and use of medical services; and by individual lifestyle factors, such as smoking, a poor diet and lack of exercise (e.g. Townsend and Davidson, 1992; Graham, 2000). Although these determinants of health may be largely seen as the responsibility of medicine (Murty et al. 2009), social work makes a key contribution in mitigating this burden of ill health. Examples in the literature of social work involvement in downstream interventions include supporting adults with learning disabilities to access screening programmes (Ward et al, 2010); accessing public health services by Pakistani women in Hong Kong (Po Ying Ho, 2010); improving psychosocial care for cancer patients (Lethborg and Posenelli, 2010) and taking action to reduce cancer inequalities among lesbian, gay, bisexual and trans people (Author 1, 2012). The focus is often individual behaviour change, for example, getting people to stop smoking

rather than tackling the underlying causes which lead to increased patterns of smoking among particular social groups. Downstream interventions are commonly characterised in understandings of social work action in relation to health (partly evidenced by the relative predominance of published papers in downstream social work interventions in health inequalities and partly, for example, by the location of social work in hospitals); in these approaches social work may be said to act as a facilitator to health care services (e.g. Gehlert and Browne, 2012).

Upstream interventions, by contrast, aim to tackle the underlying causes of inequality: the structural and social determinants of health which include poverty, discrimination, unemployment, educational achievement and poor housing (Shaw et al. 1999; Pantazis and Gordon, 2000). Upstream interventions aim to promote social justice and social and economic well-being. In these approaches, social work is not the hand-maiden to existing medical services, but a key player with a wealth of existing expertise and experience of working in collaboration with other professionals to reduce social inequalities. Examples of upstream interventions include preventing loneliness and social isolation among older people (Windle et al. 2011); supporting people in accessing meaningful work (Dickson and Gough, 2008) and assisting adults with learning disabilities to live independently (Azzopardi, 2011). *Fair Society, Healthy Lives* has widened conceptualisations of health inequalities to acknowledge that action to reduce health inequalities has focused too narrowly on disease related causes of death. The report provides compelling evidence that concerted action is needed across all levels of national and local government to tackle social inequalities:

The focus of much work on health inequalities in England, in particular the Public Service Agreement target, has been on inequalities in mortality. However, measures of mortality focus policy too narrowly on the disease related causes of death, such as the late consequences of hypertension, at the expense of more upstream interventions that would prevent the onset of medical problems. They capture inequalities in life threatening ill health but not necessarily good health and well being across life (Marmot, 2010; 41).

Fair Society Healthy Lives has proposed six policy objectives: 'give every child the best start in life', 'enable all children, young people and adults to maximise capabilities and have control', 'fair employment and good work for all', 'healthy standard of living for all', 'create and develop sustainable places and communities', and 'strengthen the role and impact of ill health prevention' (Marmot, 2010; 22-32). These policy objectives suggest that social work's role is not merely limited to preventing the onset of medical problems or supporting people's access to medical care. Rather they imply upstream implementation strategies that form the core business of social work practice. Policy recognition of the role that social work plays in addressing these upstream factors is fundamental to taking the national and, potentially global, health inequalities agenda forward and, especially in England, this will require drawing attention to social workers' contributions to programmes such as Sure Start, in working with families in areas of disadvantage.

Putting health inequalities at the heart of the social work curriculum

It is surprising to note that social work's commitment to reducing health inequalities is not reflected in the 'curricula of social work qualifying programmes or in the dominant discourse

of social work research and theoretical development' in the UK (Bywaters and Napier, 2009; 454). This is the case in the 'upstream' examples cited above, which address social inequalities, but do not locate their analyses within health inequalities debates. Although social work's contribution to health has been included in social work programmes internationally, an explicit statement in curricula standards about social work and health inequalities often appears to be missing. For example, while promoting health has been core to Australian social work education since the 1970s, the curriculum standards refer to physical ill-health relating to knowledge of the individual rather than the wider conceptualisations of health which are the focus of this paper (Retrieved 7 August 2012 from: http://www.aasw.asn.au/document/item/100). Acknowledging this oversight, the World Health Organisation issued an international mandate which urges Schools of Social Work to include teaching and learning about health inequalities as 'a standard part of the curriculum' (CSDH, 2008; 189). We were able to find only two published examples of curricular approaches to health inequalities, the first are interlinked global learning devices on the social determinants of health (SDH) (Retrieved 20 July 2012 from: http://dds-dispositivoglobal.ops.org.ar/curso/) which identify social justice, health equity and human rights as core principles for SDH. The second is a teaching and learning resource, produced by the Social Work and Policy subject centre of the UK Higher Education Academy, which developed pedagogical models for teaching health inequalities including permeation, where learning is spread throughout the curriculum; discrete modules focused on health; or inter-professional modules, where health inequalities form a core element (Bywaters et al. 2009). The Social Work and Health Inequalities Network, a collaboration of 300 practitioners and academics from 25 countries worldwide, have recently begun to develop teaching initiatives through an online symposium of Pacific Rim perspectives including Australia, New Zealand,

South Korea, and the UK (Pockett et al. 2011). Building upon this existing work and resources, we propose three content areas (alongside others including life course, theory and methods or research) where health inequalities might be usefully included in social work curricula. These are: human rights, interprofessional education and international social work and they are examined below.

Taking a human rights approach to tackling health inequalities

Human rights principles were first articulated in the Universal Declaration of Human Rights 1948 which expressed the core values and entitlements of what it means to be human. Human rights provide a framework to ensure the inherent dignity and worth of all people and the foundation for freedom, social justice and equality. The values, theories and ethics embedded in the Universal Declaration are core to the profession of social work (Witkin, 1998). As Jim Ife (2001) argues

> Social work is about people being able to realise their full human potential, and hence it is concerned with constructions of universal ideals of humanity... The important task for social workers is to (develop) ... a clear articulation and affirmation of universal human rights as a basis for a new global citizenship' (Ife, 2001; 9).

Human rights are increasingly central to the global practice of social work. The implementation of the UK 1998 Human Rights Act placed a duty on public authorities, including social services departments, to ensure that their practices, procedures and service delivery are consistent with European human rights instruments (Williams, J. 2001). Three

generations of human rights have been affirmed through a number of human rights instruments (Ife, 2001). The first largely focus on civil and political rights which ensure freedom from the curtailment of individual liberty or "negative rights" such as protection from inhuman or degrading treatment. The second are "positive rights" including the right to life, liberty, safety of the person and to respect for private and family life. The third generation of rights are particularly significant for social work because they extend the notion of rights to social exclusion, poor housing or poverty which are conceptualised in the International Covenant on Economic, Social and Cultural Rights (IESCR) 1976 as social and economic rights.

Understanding "positive" rights has not always been clearly articulated in UK social work, such as the right to a private and family life (article 8), despite having clear implications for practice. The right means that people with learning disabilities have a right to sexual relationships and it has implications for people living in residential or community care settings (Williams, J. 2001). Sexual and intimate relationships are fundamental to what it means to be human and bring intrinsic health benefits contributing to our sense of well-being. Social workers can play a key role in ensuring that service users' relationships are supported. The right to a private life also includes the "negative" right not to be subject to physical, sexual, emotional or financial abuse and local authorities have a public duty to ensure that appropriate safeguards exist to protect vulnerable adults. Social work also contributes to supporting the right to a private life through early intervention and prevention work with children and families and in gender-based domestic violence.

A human rights perspective in social work education emphasises the profession's core values and illustrates that protections are universal and thus afforded to all communities without exception. But a human rights focus is not well developed in the UK; in the search of the literature there were few published papers which had an explicit focus on human rights and social work practice and research. It is for this reason that the following discussion focuses on the exemplar of gypsy and traveller families. Gypsy and traveller families have poorer health status, lower life expectancy and higher rates of perinatal and infant mortality. Despite their greater health needs, they have poorer access to health services. Cemlyn's (2008) research highlights the less favourable services available to gypsy and traveller families in comparison to the wider population. Travellers have often avoided contact with social workers from fear of losing their children into care, while social workers have been apprehensive about visiting travellers resulting in neglect of some children's needs. The failure to recognise Travellers' status as an ethnic minority has meant that their cultural needs have been overlooked or pathologised. When Traveller children are accommodated by a local authority, they have sometimes been placed outside of their community with potentially damaging implications for their health and well-being (Cemlyn, 2008). Cemlyn suggests that inclusive and integrated services may forge a positive involvement between Travellers and social work. She identifies a range of factors which promote good practice in work with Traveller families: 'the inclusion in race equality policies, cultural awareness and staff training, sensitive outreach and non-crisis engagement with Traveller communities, liaison and co-work with specialist agencies more connected to Travellers and the active involvement of Travellers in developing culturally relevant solutions' (Cemlyn, 2008; 163).

A human rights approach to health is crucial to tackling global health inequalities (London, 2008). Three aspects shape a rights-based approach to health: their universal application for peoples worldwide, the notion of entitlements of human rights and recognition that health needs and social concerns are inter-related. The tenets at the root of social work are a commitment to social justice and equality: a human rights perspective foregrounds a vision of a just society and makes explicit social work's commitment to achieving social change (Witkin, 1998).

Interprofessional education as a focus for understanding health inequalities

Inter-professional education (IPE) brings together students from disciplines as diverse as health, allied health professions, education, criminal justice and social work in recognition of the overlapping nature of health and social problems. Learning alongside other professionals helps to break down some of the misconceptions about the role of other professionals, it challenges stereotypical assumptions and fosters effective communication. A well-designed programme of inter-professional education can facilitate the learning of new skills and knowledge and enable students to implement their learning in the workplace (Carpenter et al. 2006). The strategy *Working together, learning together* specifically identifies working effectively in teams and shared learning opportunities as key to 'helping keep people healthy and work to reducing health inequalities' (DOH, 2001; 7). A raft of other policy and legislative drivers have focussed on the role of partnership in reducing health inequalities and on closing the gap in infant mortality and life expectancy among disadvantaged communities (e.g. DH, 2010; HM Government, 2010; 2011).

Much of the focus of research in interprofessional working, however, has been on improving relationships between different professional groups: questions about what types of collaboration are the most effective or on organisational processes which contribute to increased efficiency (Smith and Anderson, 2008). Studies have considered the impact of joined up working on information sharing, the benefits of co-location in increasing the amount and quality of contact between professionals and avoiding the duplication of services (Frost, 2005). There has been considerably less research attention, however, to the fundamental aims of inter-professional working as outlined in the 1959 Younghusband report which argued that it was 'essential for healthcare teams to collaborate with social workers for the benefit of service users and patients' to improve health outcomes (Tope and Thomas, 2007; 36). While there is evidence that a failure to work together has led to a number of child deaths and a breakdown in communication between professionals is commonly cited in serious case reviews, there is relatively little research which investigates the effectiveness of inter-professional working in terms of health and social care outcomes for service users. In the few papers which provide an evidence base of the benefits for service users, two main themes emerge: a better journey through health and social care services and improved health outcomes for service users.

IPW enables a better journey through health and social work services
The benefits for service users resulting from IPW are identified through a better process and improved access to care (Schmitt, 2001; Ward et al. 2010). Service users value joint working as it helps them to navigate the institutional barriers which have prevented them from receiving the care they need. Historically, professionals were reluctant to share what they knew about users; this was partly from concerns about confidentiality and partly a desire to

protect professional boundaries. Good communication between professionals may result in improvements in the quality and effectiveness of communication with service users; for example, the introduction of shared methods of assessment has removed the need for service users to repeat their story to a number of different professionals involved in their care. Joint commissioning means that services can be planned around the holistic needs of services users rather than focussing on a single outcome or objective.

IPW leads to improved health outcomes for service users

Collaboration improves the quality of care and also leads to an increase in the number of services accessed which may also lead to improved health outcomes (Schmitt, 2001). Families with disabled children who receive co-ordinated services report better relationships with staff, fewer unmet needs, fewer feelings of isolation or burden and higher satisfaction with services (Frost, 2005). A Department of Health funded study, the Outcomes for Adult Social Care Initiative, which examined the health impacts for older people found that integrated working enabled them to remain in the community. Given that a key health and social care objective is to support older people to continue to live independently, this was identified as a measurable benefit from joint working (Davey et al. 2005). Integrated structures have also been found to impact positively on the operation of care management for vulnerable older people (Challis et al. 2006). Carpenter et al.'s (2006) evaluation of a postgraduate programme where health and social care professionals worked together to provide new community mental health services also showed health benefits for service users. People with severe and enduring mental health problems showed improvements in their social functioning, life satisfaction and daily living skills. The development of social relationships is essential for service users' health, well-being and quality of life.

Learning about health inequalities through Inter-professional Education

Experiential learning about the role of collaboration in work to reduce health inequalities has been productive in social work education. One example of an innovative approach is the Leicester model of Health in the Community which draws on a pedagogical approach of problem based learning (Smith and Anderson, 2008). Students are located in city centre communities where health and social inequalities are greatest. The ethos of the module is to enable students to experience at first hand the daily living conditions of people for whom they will provide care when they are qualified professionals. Students are assigned to mixed learning groups drawn from a range of health and social care disciplines including social work, medicine, nursing, physiotherapy, speech and language therapy and pharmacy. Over the intensive programme, students develop their awareness of local services and community resources and gain an understanding of the social issues for people in the neighbourhood. The student groups work together to prepare for a home visit, where a service user takes a role as an informal educator and reflects upon their experience of different professionals' involvement in their care. When inter-professional working had limited benefits, service users highlighted conflicting expectations, unresolved priorities and a lack of communication between professionals. Where inter-disciplinary working was beneficial, service users described relationships founded on mutual respect and trust and a commitment to work together with them to achieve good outcomes.

Joint learning between social work and health professionals helped to identify the social causes and consequences of health problems. Students understood that service users' health and well-being were deeply affected by the social conditions in which they lived their

lives: poor quality housing, lack of transport to visit friends and relatives, restricted diet, reduced mobility in the home and reduced access to benefits because they were unable to navigate the complexities of the welfare system. Inter-professional education can enable students to collaborate alongside those from other professional disciplines and offers opportunities in joint working to reduce health inequalities.

Locating health inequalities within an international perspective

Current efforts to develop an internationalisation strategy on social work programmes in the UK seek to make the curriculum more relevant to students whatever their national or cultural background (Powell and Robison, 2007; Higher Education Academy (HEA), 2011). Students now have a heightened awareness of international issues and widening debates to include global health and social inequalities is an important way of engaging their interest. This is reflected in recent literature (Bywaters et al, 2009; Harrison and Melville, 2010; Hugman, 2010;) that addresses the dynamic relationship between global and local issues that is played out in the context of international monetary policies, world trade and patterns of migration as well as conflict within and between nations and the growing threat of climate change. This requires that attention is paid to both the macro and micro levels of practice, recognising that practice at the 'local' level, focused on individual and family situations, also needs to be understood within wider systems of inequality and human need (Hugman, 2010; 85). This is also highlighted by Williams who refers to

> …'a "global care chain" where (usually female) migrant workers move from poorer countries to provide domestic service for individuals and families in richer countries' (Williams, F. 2001: 470).

This draws attention to the potential complexities involved when co-ordinating care packages to support people in the community and the wider international context that may influence the health and wellbeing of service users and of their carers.

Hugman (2010) and Morrison (2010) also highlight the value of a social development approach, currently more familiar outside the UK context, intended '... to promote the well-being of the population as a whole...' (Midgely, 1997; 181). This opens up fundamental questions regarding the boundaries of the social work role and professional flexibility and the way in which this may be understood in a range of difference contexts.

Notwithstanding the increasing attention to the internationalisation of the social work curriculum (HEA, 2011), in the absence of a systematic approach to this area, it may be helpful to acknowledge and build on the opportunities and resources that may present themselves. For example, the experience of a mental health partnership between higher education institutions in the UK and Zambia, enabled a Zambian visitor to present her perspective on women's mental health based on her experiences, to an audience including social work students as part of their mental health teaching. This presentation drew attention to different cultural understandings of mental health and distress and the impact of gender, all relevant as part of preparation for practice in a culturally diverse society. The session also highlighted the inequitable distribution of resources for health at a global level with patterns of migration, the impact of HIV/AIDs as well as the exodus of qualified professionals from a resource-poor to a resource-rich country being seen as influential when considering the social determinants of health.

The experiences of asylum seekers, seeking refuge from political oppression, war or poverty also illustrate the relevance of locating a consideration of health inequalities within an international perspective. This might include the impact of the social determinants of health in their country of origin and for some the impact of torture or civil strife, the effects of a hazardous departure and journey and the challenges in accessing adequate health care on arrival in a strange and sometimes unwelcoming environment. The limited support available in terms of housing, employment, education and financial support can also be seen to impact further on health. Such considerations are also relevant in respect of a social work response to trafficking and trauma.

Fostering an understanding of the international contexts and constraints within which social work is understood and practiced internationally can be seen as contributing to social workers and social work students to 'decentre' their own practice and to learn from others' experiences. Additionally it helps to inform and shape the understanding of service users who may have moved between countries or whose experiences of 'health' are founded in very different contexts.

Conclusion

As articulated in the Rio Declaration 'health inequalities arise from the social conditions in which people are born, live, grow, work and age, referred to as the social determinants of health' (WHO, 2011; 2). It is worth remembering that while recognition that health and social inequalities are intrinsically interlinked is not a new agenda, it is controversial: for example, the response to the publication of *The Spirit Level: Why equality is better for*

everyone (Wilkinson and Pickett, 2011) see for example

http://spiritleveldelusion.blogspot.co.uk. The Rio Declaration, together with *the Spirit Level*

presents an unparalleled opportunity to secure the commitment of governments

worldwide. Social workers clearly contribute to addressing health inequalities through

downstream interventions for example, in hospital based social work or facilitating access to

health services for people with learning disabilities (Ward et al. 2010). It could be argued,

however, that that the major focus of social work practice is in those upstream

interventions, acknowledged in *Fair Society, Healthy Lives*, as having the potential to make

the greatest difference in improving people's health and well-being, such as maximising the

capabilities of older people and promoting their independence, for example, through

reablement (Arksey et al. 2010). In work with children, social workers have a clear role in

giving every child the best start in life including promoting the educational achievement of

looked after children which is a key Marmot policy objective. Social work educators are

keenly aware of their role in teaching and learning to address social injustice and in

contributing to downstream health interventions. Embedding a *social determinants of*

health approach in the social work curriculum can develop a more nuanced understanding

of the distinctive contribution the discipline makes through upstream interventions to

reducing social and health inequalities.

Social work educators can take a number of opportunities to integrate teaching and learning

about health inequalities: World Social Work Day presents an occasion to raise the agenda

about the widening gap in health inequalities as a global concern for social work education.

The Global Agenda for Social work provides a focus for discussion about the impact of

inequalities on people's health and well being and includes key pledges on the social

determinants of health (IFSW, 2012). As the social work curriculum in England is being reviewed to ensure that the requirements for the Professional Capabilities Framework are in place, it is timely to consider creative ways to enable students to apply an understanding of the social determinants of health to their practice and recognising their contribution to tackling health inequalities within a wider agenda of social justice.   At the Joint World Conference of Social Work and Social Development in Stockholm in 2012, Professor Sir Michael Marmot gave a keynote speech in which he said that the social determinants of health should be 'bread and butter' for social workers and welcomed the opportunity to foster a social movement and invited social work educators and academics to join the movement (Retrieved 13 August 2012 from:

http://swsd2012.creo.tv/tuesday/michael_marmot/d3p2-michael_marmot). The challenge for educators is to ensure that new generations of social work students are keenly aware of the essential role they play.

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