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What is This?

Inequalities in health and community-oriented social work

Lessons from Cuba?

● Dave Backwith and Greg Mantle

Social justice is, as the World Health Organization Commission on Social Determinants of Health (WHO CSDH, 2008) reminds us, 'a matter of life and death'. While the stark differences in mortality rates and life expectancy between rich and poor countries might be the most obvious example of this, it is also true that 'Within countries, the differences in life chances are dramatic and are seen in all countries – even the richest' (WHO CSDH, 2008: 26). As the Commission demonstrates, the roots of these inequities lie in social conditions, suggesting an important role for social work in this area. Unfortunately, the Commission says very little about the type of social work that might be appropriate: nevertheless, the report does provide fresh impetus to the debate about what social workers might contribute to tackling health inequalities. In this article, we suggest that a community-oriented approach to social work is required. In making a case for this, we review the progress of the government's drive to reduce inequalities in England,¹ arguing that this has, thus far, been largely unsuccessful because it has primarily been pursued through health-care services, while addressing the wider (social) determinants of health has been a secondary consideration. In contrast, we offer the example of Cuban community-oriented social work (COSW) which has helped maintain population health at a level that stands comparison with much wealthier nations, despite the

Key words ● community-oriented social work ● Cuba ● health inequalities

hardships and inequalities which followed economic collapse in the 1990s. In many ways the Cuban situation is unusual, perhaps unique, so we are not arguing that Cuban social work methods can be readily transferred. Rather, we suggest that, in the neglected field of tackling health inequalities, social workers can learn from the general approach taken in Cuba. To establish the context of this discussion, we begin by defining key concepts: COSW itself, health inequalities and inequity, the health gap and the health gradient.

Community-oriented social work

Definition in this area of theory, policy and practice is particularly fraught because so many different meanings have been ascribed to constituent and combined terms over the years and across different countries. 'Community' itself is a highly contested term. It can refer to geographical locality or shared interest (Bulmer, 1987), for example, and is sometimes employed loosely, as if such a distinction is unimportant. When combined with the words 'care' or 'work', further definitional complexities arise. Ritchie (1994) picks out four major approaches to understanding 'community care' that, respectively, call for: a better balance between residential and home-based care; a more coordinated, inter-agency organization of care; a comprehensive shift away from existing obsolete provision; and, finally, the radical reconstruction of society itself. Payne (1997) examines the broad notions and expressions of social and community development, and their connections with social work. He concludes that, while these perspectives offer a wider social focus for intervention with oppressed people than systems theory (which looks at the interpersonal level) they both serve to reproduce the existing social order.

Mayo (1994) provides an account of the development of community work in the UK, from the settlement houses, local centres for delivering social work services established towards the end of the 19th century, to the Seebohm Report (1968: 147) which called for 'a wider conception of social service, directed to the well-being of the whole community and not only of social casualties, and seeing the community it serves as the basis of its authority, resources and effectiveness', and from this, to the interest in community and prevention apparent in the Children Act (1989) and the National Health Service (NHS) and Community Care Act (1990).

The concept we have chosen to grapple with is COSW and it is important to begin by acknowledging that community work is not limited to social work. It has strong links, for example, with youth work

and with housing, tenants' associations and the like. But a social worker could be involved in very similar ways within a community in terms of political participation, advocacy and community organizing, although in England this is a rarity. The job titles 'community social worker' or 'community-based social worker' to be found in press advertisements tell the reader that the work will be undertaken outside the institutional walls of a residential establishment. It is fair to suggest that, within the social work context, 'community-oriented' carries a different meaning from 'community-based', although the difference in terms of actual practice may be slight.

Given the widely varying histories and manifestations of social work in different countries, it can safely be predicted that the interpretations of COSW will be similarly multifarious. So, attempting to 'compare' COSW in Cuba with what is meant and taking place in England is no simple task. Strug (2006), for example, presents contemporary social work in the West as essentially non-community-oriented, instead highlighting its individualism. COSW in England is, at best, relegated to the sidelines although, in response to Strug, it is possible to point to the work undertaken by the non-state sector, in particular in path-finding new approaches.

Health inequalities: concepts and determinants

Internationally, there is increasing concern about both the scale and causes of social inequalities in health. In terms of scale, the WHO CSDH (2008) opens with a powerful example of differences in children's average life expectancies: 'In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years.' Disparities within countries are also vast; in the USA, for example, white men living in areas with the best health live, on average, nearly 20 years longer than black men living in the worst areas (Marmot, 2001).

Whitehead and Dahlgren (2006) argue that health inequalities have three distinguishing features: they are systematic, socially produced and unfair. They are systematic in that they occur consistently between population groups. The example above of differences in life expectancies by ethnicity and area in the USA is one instance of such differences. Health is socially produced in that it is people's social conditions that largely determine their health. Poverty, housing conditions and diet are obvious examples of this, but factors like social integration (or inclusion) and stress are increasingly recognized as 'social determinants of health' (Wilkinson and Marmot, 2003). Some differences in

health between population groups are, of course, less directly socially determined. For instance, that women tend to live longer than men is largely biologically determined and so not generally considered unfair. But, where women's greater natural longevity is reduced by patriarchal social conditions, this is unjust and so an inequality. Seen in this way, a crucial aspect of health inequalities is that they are subject to human agency: people can take action to reduce them.

Two useful concepts which illustrate the systematic occurrence of health inequalities are the health gradient and the health gap. The health gradient is simply that 'Life expectancy is shorter and most diseases are more common further down the social ladder in each society' (Wilkinson and Marmot, 2003: 10). The health gap is the extent of differences between people at the top and bottom of social hierarchies. For instance, a study of the health gap in Russia found: 'In 1980 men with the lowest level of education had a 3-year lower expectation of life at age 20 than those in the highest-education group; by 2001, this difference had increased to 11 years' (Murphy et al., 2006: 1296).

The systematic occurrence of health inequalities is a product of the social determinants of health: they are generated by structural inequalities which are best addressed at a collective, rather than individual, level. The attention given to lifestyle choices in Western societies, notwithstanding: 'individual lifestyles are embedded in social and community networks and in living and working conditions, which in turn are related to the wider cultural and socioeconomic environment' (Acheson, 1998: 6). For people at the wrong end of health inequalities the social determinants of health are neither benign nor neutral. Rather:

health inequities . . . 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 health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. (WHO CSDH, 2008: 1)

In England, the government made reducing inequalities in health a priority, and this was given renewed focus by the announcement in February 2001 of the national target for a 10 per cent reduction in health inequalities, as measured by infant mortality rates and life expectancy at birth, to be achieved by 2010. Many policy documents and reports have followed in the wake of these targets, including *Tackling Health Inequalities: A Programme for Action* (Department of Health, 2003). This document sets out detailed roles and responsibilities and includes some passing mention of social workers.

This commitment has made England a 'world-leader in policy development and practical action in health inequalities' (Department of Health, 2007: 14) but, so far, the results of this effort have been mixed. The latest review (Department of Health, 2007), using data for 2004–6, found that although there have been improvements in both infant mortality rates and life expectancy for the poorest social groups, these have been matched by improvements for all groups in society: the health of the general population is improving but the health gap remains wide and, by some indicators, is wider than it was 10 years ago, particularly for women.

In some respects, the failure to narrow the health gap in England is not surprising; health inequalities are 'persistent, stubborn and difficult to change' (Department of Health, 2007: 12). But, while there might be inherent problems in reducing health inequalities, the nature of the targets has introduced further tensions. First, while it follows from an understanding of the primarily social determination of health that long-term reductions in inequalities would best be achieved by changes to structural inequalities in society, the drive for quick wins to achieve the 2010 targets is at least partly responsible for health-care services being placed at the forefront of the campaign. Second, the life expectancy aspect of the target has an area focus on the Spearhead group of the 70 most deprived local authorities. There are a number of difficulties with this. One is that it excludes disadvantaged people and places which do not fall within the selected areas: more deprived people, in fact, live outside the Spearhead authorities than live within them (Department of Health, 2007: 25). Furthermore, it appears that life expectancy is increasing more quickly for the better off than for the poorest groups in the selected areas. A straightforward explanation of why health inequalities in England have widened would be that, despite the government's pledge to 'end child poverty in a generation', Britain remains a very unequal society. A recent review found, for instance, that: 'Income inequality has risen for a second successive year [in 2006/07] and is now equal to its highest-ever level' (Brewer et al., 2008: 1). Income is, of course, central to how people live and has obvious relevance to health in that it determines things like whether people have to make the choice between heating and eating in winter. But, as we have seen, the determinants of health are complex and, in affluent societies, health inequalities are closely associated with psychosocial stress caused, as Wilkinson (2005) has argued, by the lived experience of social inequality.

Health inequalities are not only unjust; they also offer insights into the 'relationship between the individual and society and how we are

affected by social structures' (Wilkinson, 2005: 19). Social workers are familiar with such manifestations of social inequality and, probably, better equipped to deal with them than most in the caring professions. To some extent, the need to look beyond the NHS is both acknowledged and addressed in the drive to reduce health inequalities in England. Emphasis is given, for instance, to joint working between health services and local government. However, in terms of action to reduce inequality, the focus remains very much on securing behavioural change among individuals in the groups worst affected; for example, by stopping smoking campaigns and empowering 'people to take responsibility for their own health' (Department of Health, 2007: 72). As complex as health inequalities are, the problem with this approach is clear: 'Public health is principally about organising society for the good of the population's health . . . it is no more a matter of individual choice than the weather' (Mawle, 2005: 6). It might then be helpful to look at an example of a society in which 'the good of the population's health' can, with some justification, be said to be a key organizing principle and, in particular, to look at the role of social workers within that ambition.

In global public health, Cuba presents a paradox: by economic measures it ranks as a developing country while, in population health outcomes, it stands comparison with first-world countries. In comparison with the USA, for example, the current *Human Development Report* (UNDP, 2007) gives both countries an infant mortality rate of six and life expectancy at birth as 77.7 years for Cuba and 77.9 years for the USA. The USA is, of course, much wealthier than Cuba; average annual expenditure on health care is over \$6000 per head compared with only \$229 in Cuba.² Telling as the comparison with the USA might be, in terms of health inequalities, Cuba might be more appropriately judged in the context of Latin America, 'one of the most unequal regions in the world' (Reed, 2005: 1). Farmer (2007) draws a sharp contrast between Haiti, the poorest country in the region, and Cuba:

The leading killers of young adults in Haiti are tuberculosis and HIV; Cuba has the lowest prevalence of HIV in the hemisphere, and remarkably little tuberculosis. I could rattle off any number of indices leading to the same contrasts. There's a saying in Cuba: '*We live like the poor, but we die like the rich*' (s. 10).

There is not space here to discuss the Cuban public health system in any detail.³ Suffice it to note that it is founded on 'the conviction that universal, community-oriented primary care must be at the heart of the health system, staffed by professionals whose preventive focus also grapples with social determinants' (Reed, 2005: 1). This is set in the context of a longstanding government commitment to social

egalitarianism, delivered through universal, free social services with price controls and rationing of food and other essentials (Spiegel and Yassi, 2004).

Historically, Cubans' capacity to 'die like the rich' owed something to the very favourable economic relations their tropical socialist state enjoyed with the Soviet bloc. When that disappeared and the US economic blockade tightened, the effect was catastrophic: 'From 1989 to 1993, the external shock pushed the economy into free fall . . . malnutrition – unknown in Cuba for generations – became widespread' (Gott, 2004: 288). Remarkably, the economic collapse caused only 'relatively modest and short-lived' disruption to the long-term improvement in population health (Cooper et al., 2006).

It was helpful for the maintenance of this trend that this 'Special Period' (in time of peace) coincided with the third phase of development in Cuba's public health system. This involved decentralization, bringing health care under local government control, the adoption of a community medicine model and the consolidation of social participation and intersectoral action (Castell-Florit Serrate et al., 2007). In so far as this equates with community involvement and mobilization, Spiegel and Yassi (2004: 101) report 'an extremely high level of social capability to undertake collaborative activity at a local level to address collective needs'. But they note the need to monitor how this community participation will adapt to 'changes prompted by globalization'.

The changes referred to are the restructuring of the Cuban economy, necessitated by the 'Special Period', notably the re-emergence of tourism as a major sector of the economy, intended to attract foreign investment and currency, and associated liberalization including 'the [temporary] legalization of dollar holdings, the opening of the island to joint ventures and the sanctioning of "cuentapropias", or private micro-enterprises' (Elliott and Neirotti, 2008: 383). This Cuban-style capitalism has revived the economy, at considerable social cost: 'Professionals educated in medicine, engineering and education are quick to flock to tourism service jobs, whether it is being a taxicab driver, a waiter or even a prostitute. The Cubans who choose to be self-employed earn on average twenty times more than their previous state job' (Elliott and Neirotti, 2008: 386). Although there are no official poverty statistics, there seems little doubt that it has grown significantly; Uriarte (2002: 26) describes the growth in income inequality as 'the most critical effect' of economic liberalization.

Until recently, health inequalities have received little specific attention in Cuba. Partly, this is a consequence of the priority given to reducing social inequalities more generally, one result of which has

been that the regional (urban/rural) health gap, as measured by infant and maternal health indicators, narrowed considerably between 1980 and 1999 (Moliner et al., 2002). More recently, a proposal has been developed for a health equity monitoring system with a view to identifying the health impact of: 'the substantive changes that have occurred in the living conditions of the population and other economic and social spheres, together with the reduction of the homogeneity that characterized the Cuban population' (Marquez and Pardo, 2005: 17). More specifically, in relation to Wilkinson's theory (2005) about the psycho-social causes of health inequalities, recent research by Spiegel et al. (2007) found that, while tourism was perceived to have negative effects on a 'wide range of health concerns':

Issues related to psycho-social impacts . . . were raised more frequently than other impacts in the focus groups . . . Addictions and obesity were consistently reported less emphatically than changing values, disparity and dysfunctional families . . . [While] a risk factor for mental health stress was attributed to the 'prominent [economic] difference between the workers in tourism and the rest of the community (p. 62).

Spiegel et al. (2007) identify programmes that tackle these problems, some with the aim of developing community capacity and health improvement, needs which COSW has been developed to address.

Community-oriented social work in Cuba

Social work is fast strengthening its international base. There is more public scrutiny of and debate about social work in different countries which is helpful for understanding the Cuban situation, albeit indirectly. Ferguson and Lavalette (2007) present case studies from countries including India, South Africa and Nicaragua, and call for a review of activism in social work. They argue that, while neo-liberal globalization has been accompanied by the emergence of social work in many poor countries, western social work is in crisis because of the ascendancy of market-based approaches. This is an important contextualizing debate for understanding Cuban social work, given the country's post-revolutionary, anti-capitalist tradition.

It is fair to say, however, that the literature addressing social work in Cuba remains sparse. Dominelli's (2008) review of an anthology by Cuban and Swedish authors (Mansson and Proveyer Cervantes, 2005) includes this account of her visits to Cuba:

I have found some impressive examples of practice . . . where social workers and health practitioners hold multiple roles and often join together to challenge the [Communist]

party's proposals and empower people accessing their services to ensure that . . . they get what they need in extremely difficult circumstances . . . These are strengths that social workers in western countries can learn much from in responding to the needs of the poor, marginalized groups in these locations. (Dominelli, 2008: 269)

Ocasio (2008) tells us that Cuban social workers are considered to be the 'army of the healers of the soul', closely connected with families and communities, and proactive in their approach: 'Their mission in Cuba is basically to become friends of . . . neighbourhood people and utilize this close relationship to assess their needs . . . Social workers . . . go out and seek clients, block by block, meeting people, learning names and the issues they present, collecting figures and statistics and working to address those issues presented.' However, this picture says little about how social workers manage more complex engagements involving child and adult protection issues.

Strug (2006) provides a detailed exposition of the history and current nature of social work in Cuba. He argues that COSW emerged in the 1990s in response to the socio-economic problems of the 'Special Period' and a need for social workers to undertake community practice with vulnerable groups. While Cuba's post-revolutionary government created mass organizations, such as the Cuban Federation of Women that included neighbourhood activists called empirical social workers, the first trained social workers appeared in the 1970s and were given the task of assisting health professionals. Strug refers to these social workers as technicians, trained to assist doctors and nurses, and to know about public health issues (p. 752). In the 1990s, the government initiated a 'neighbourhood movement' to, as Uriarte (2002: 44) puts it, fill the 'vacuum that existed at the community level', with the result that 'community-based organizations, hundreds of them, developed in Cuban barrios to address urgent needs facing urban dwellers in the Special Period'. Power was delegated to popular, local organizations, particularly people's councils where: 'Social workers became regular participants . . . They advocated for at-risk community members who needed special services, such as larger monthly pensions for the poor elderly or for medical equipment for the disabled' (Strug, 2006: 755). Community-oriented social workers were required and it was felt that the public health-oriented social work training institutes would not be able to produce them. University-based social work was reshaped and largely dedicated to training unemployed youth who 'worked as emergentes in their own communities after they finished their training. They were named emergentes because they addressed emergent social problems, such as child malnutrition, school absenteeism, and the needs of the elderly for economic and social assistance' (Strug, 2006: 755),

so that social work is now executed in Cuba by three different groups: health technicians, university educators and community-based *emergentes*.

Strug (2006) argues that the development of COSW reflects the wider collectivism championed by the Cuban government which, unlike western states, has promoted a community approach. In rejoinder, attention might be brought to the fact that social workers had, for decades, been little more than technical aides, but what must be acknowledged here is the urgency of the need to meet the post-1959 crisis in the health system caused by the mass exodus of doctors and other health professionals.

Conclusion

Our argument is that, in England, insufficient strategic attention has been given to the link between health inequalities and social work. In understanding why this is so, the historical tensions between social work and health more broadly might be pointed to, but the lack of focus specifically on the social nature of inequalities is also to blame. Narrowing the gap has proved to be very difficult but, in order to reduce health inequalities effectively in the future, the government needs to harness the concerted action of all sectors within its province – health, employment, social care, housing, community development, etc. – and, within this jigsaw of policy and practice, social workers would be expected to play a part, albeit a modest one. Community-oriented social workers could, arguably, operate well in this environment because they would more readily appreciate the interplay of factors leading to disadvantage and be able, in concert with other agencies, to address them. Importantly, they would reach out into communities, identifying need, taking steps to meet it and feeding information back into the policy-making process. In Cuba, it does appear that this already happens and that England can, therefore, learn something from the Cuban experience. However, we do not want to present Cuba as an ideal model. As already noted, there is little data on health inequalities there and as yet no body of empirical evidence to show whether or not COSW has any significant impact. Nevertheless, should socio-economic inequalities continue to grow and social problems come more sharply to the fore, calls for COSW may grow louder. The attractions of an outreach approach to locate vulnerable individuals and groups in an increasingly aged population may also be more difficult to ignore. Waiting for people to come to the office, so to speak, is likely to become less of an option.

More analytical work is needed on the specifics of how COSW can address health inequalities in different settings. But, while it would be

naive to suggest that Cuban methods could simply be transferred to different contexts, it does seem reasonable to suggest that, for instance, COSW could contribute to narrowing the obstinately wide health gap in England, not least in the deprived areas where inequalities are most extreme.

Notes

1. Devolution, the creation of national assemblies in Wales and Northern Ireland and a parliament in Scotland, has introduced a potentially confusing situation in health policy whereby the UK parliament (Westminster) passes legislation which applies only to England. Here, where we refer to the policy drive to reduce health inequalities we use 'England' (rather than 'the UK').
2. All figures are for 2005; dollars are purchasing power parity US dollars.
3. For this see the documentary film '¡Salud!' and the extensive resources on its website: <http://www.saludthefilm.net/ns/main.html> (accessed 13 September 2008).

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