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CURRENT EXPECTATIONS OF SOCIAL WORK DISCOURSE AND INTERVENTION IN HEALTH SECTOR

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This article is devoted to the social factors of health and the role of social work in providing health care in the social system from the different sociological points of view. Special attention is paid to the health care in Greece as a result of ideological, demographic and political processes.

Keywords: health, health care, social work, international experience of social work, social work in Greece.

Health is widely recognized as the most important, basic and essential social resource. It is defined as a social, economic and political issue and above all a human right (WHO, 2007). Governments, organizations and services are responsible to plan, implement and monitor policies and measures in favor of its improvement and effective maintenance.

With regard to Social Work, health sector was the source provided the framework for its evolution and establishment as a science. Social work focuses on vulnerable and oppressed groups and their interaction with their social environment, where health issues and social needs originated from, are top priority. Social Workers nurture multifaceted, direct involvement with patients and their families in hospitals, health centers and in community care programs, as well as indirectly through health and welfare consultation, advocacy and networking of people suffering from a physical or mental health disease or from those affected by that disease (parents, unemployed, students, pupils, etc).

Discourse is a key concept of this paper, meaning *"how is it that one particular statement [appears] than another",* (Foucault, 1970:8), which is opposed to the common perspective of the text. For Foucault (1970:17), "disciplines constitute a system of control in the production of discourse, fixing its limits through an action of an identity taking a form of a permanent reactivation of rules". According to Rojek and colleagues (1988:129), discourse is *"a framework in social life, which is not similar to us that we are barely conscious of it, so we can not choose to avoid or reject its rules, which makes it possible or impossible to speak about a particular issue or object".*

Space does not permit a full analysis of it here, what I will be doing is drawing on this approach, to present some ideas in such a way that they can be reflected in modern social work practice.

Social work discourse is expressed in direct practice (face to face, skills, attitudes and ways of intervention), in inter – professional collaboration and consultation, in education (teaching, supervision), in research (the service users' voices) and in social worker's inter-personal, informal prescriptions of the service users and their ways of living. Through discourse, social workers disseminate sensitive issues of both social work acceptors and of governmental and non governmental policies targeted to them. With the words they choose when referring to them, or to the criteria of the prioritization of their needs and strengths. Also, with the words they choose when writing reports and defining patients' rights to the service/ state/ NGOs, etc.

Following the premises of the Foucauldian concept of discourse, this paper argues that theory, practice, professional knowledge and power are held in a close interrelation, strongly affected by the existing political system. Its aim is to examine health social work challenges in the modern sociopolitical context, which is dominated by ideas of conservatism and economic rationalism (Giles, 2009: 526). How has professional discourse contributed to power and to social rights in the health multidisciplinary framework? How can social workers struggle over what a patient-centred social work would be when the patient has been in many countries, or is going to be replaced of a consumer-centred process?

This challenges social workers to replace the discourse of disadvantage with a discourse of equality and how a patient is affected by his social surroundings, and to maintain and upgrade the indiscrimination practice. The field of health social work can be strengthened by a critical analysis of

different assumptions and overlapping dimensions of health promotion and social justice concepts, and by an awareness of practitioners' successes and failures in integrating these two perspectives.

Social work's contribution to the evolution of the bio-social and health care process

Social workers have played a major role in the health care system, especially in hospitals, throughout the 20th century. The first medical social worker, Mary Stewart, was appointed in 1895 to the Royal Free Hospital in London, where Ida Cannon, was employed by the medical director Dr Richard Cabot at Massachusetts General Hospital, in 1908, (Cabot, 1915/1977). While social work's community health practices can be traced to the 1880s and the work of Jane Addams and the settlement house movement (Conway 1992, cited in Giles, 2009: 528). Similarly, the first mental health social worker was carried out at the Tavistock Clinic, in 1920, the second was done so in 1927, at the Jewish child guidance clinic in Hackney.

Health social work development was affected by issues relating to health policy and delivery, the grow of hospital construction which followed World War II, and to the disease focus of care. The hospital-based social work was implemented in parallel with community interventions, primary care, integration of health and mental health, prevention, practice research and quality assurance, and with structuring patterns of interaction between with social networks, informal helping systems, and formal sources of care. Mental health became a specialist area of social work with a clear professional identity.

Over the past century, the main ideology stream has been the biomedical worldview, where disease is accounted for by deviations from the norm of measurable biological (biochemical and neurophysiologic) variables and by the mind/body dualism and the separation of mental from somatic. Social workers working both inside and outside formal health settings, were opposed to this. They supported the bio psychosocial model, integrating the vision of a patient as a person in-situation, analogous to the social work concept of person-environment. This model recognises that biological factors are necessary but not sufficient for understanding a human being in social work (Rock, 2002: 11). Social workers used to focus on, and care for, ill people and their achievement of general and specific function and proving that psychosocial techniques increase the quality of the therapies' results. Social work' acceptors, include patients and family members, and people with life-limiting illnesses served by the hospice or at home and their carers.

Social workers experienced, and still experience, millions of cases of both indigenous and non indigenous peoples who, as a result of social factors such as geographic or symbolic (living in deprived townships) location, ethnicity, cultural, educational, employment and financial status, do not have equal access to effective health care. They were stressing the health risks arising from the uniqueness of each communities' geographic, cultural characteristics, and the importance of direct access to the proper therapy and of the personal linking - gaining emotional support with respect for individual liberty and freedom of choice.

They became leading lights in the movement from hospital and institution care to the community and especially in the continuity of care during the move from the asylum to the community settings and Hostels. Mental health social workers carry enormous responsibilities and do important preventive work.

By supporting the rise and development of the feminist and disability movements, social workers strove for subsequent health policy changes and became involved in a driving shift away from the service-led assessment to a need- based approach, stressing how the new needs were conceptualized.

This brought about drove to the evolution of holistic approaches, which enlarged the frame of their interventions. By working in collaborative spirit, discretion and openness, they developed networks and front-line practice negotiations of shared responsibilities with informal welfare and solidarity resources.

Social workers continue to promote a social model of health that questions the medicalization of social ills and to underline the evidence from research concerning the widening gaps between health and well-being and the huge numbers of people and communities who are excluded from an illness-free lifestyle and from adequate treatment, when it is needed. Anti-oppressive theorists have guided social workers to keep aware of social, cultural and structural injustices and review of service users understanding and power, as a prime task of their clinical and community interventions (Dominelli, 2002, Fook, 2002).

Modern challenges affecting Health Systems and Social Work provision

Social workers in health care have created many new practices and approaches to meet the changing context and social realities of the previous century's health care system. Many different parameters have

contributed and affected modern challenges for both, clinical and generic practice in all levels of health sector.

Technological developments have contributed on changing the characteristics of illness and treatment. The pestilential diseases are no longer causes of death and diseases, which were formerly fatal, have become temporal or chronic (in nature). The time for hospital treatments has been cut short, where the time for home and community care has been extended and more often than nor, for life. Social Workers must be flexible and ready to apply both short term processes within hospitals and long term, holistic and strengthening approaches in home and community care.

Due to medical and pharmaceutical technology, the average life expectancy has increased. People live longer with more opportunities to deal with chronic problems and the psychosocial needs, they invariably produce. Technology offers various, specific equipment for temporary and permanent disabilities. Social workers have to ensure that the interested has access to, and the acquiese of them, as a personal equipment (access to his/ her home after reconstructions - placing of an exterior elevator -, and to the public buildings - accessible transfer from home to schools, social services etc).

In addition, social workers have to deal with new issues which have a heavy impact on a persons social functioning, such as new diseases (HIV, H1N1), social pathologies (drug addiction, environmental pollution, stress) and the long term therapies and medicine of those suffering from different types of cancer. People in bereavement or in grief express themselves with physic and emotional reactions in very different ways according to the cultural and religious beliefs and experiences.

Social workers have developed supportive processes, using individual, family, group and art therapies, counselling them and their carers etc. Their discourse and interventions focus on increasing positive opportunities for gaining and keeping dignity and integration in different stages of their life, and for tackling the various forms of stigma.

As social work implementation is interrelated with social conditions and its provision is oriented by the existing social policies, continuing social change and welfare reform has seriously affected it and its main" receivers": families and individuals in family roles.

As regards social change, it can be in the form of population decline and ageing, family fluidity, instability insecurity within families especially with domestic violence and abuse, affects the family shape and functioning. The widening gap between work-rich and work-poor people and growing inequalities between families (one parent and large families, also older people living alone are most exposed to poverty).

With regard to my country, Greece, demographic ageing and uncertain changing conditions in employment have affected family values and gender roles and have had a substantial impact on the family structure. Fluidity, as a way of organizing private life, is the main characteristic of the modern Greek family (Mousourou 2005). At the same time, preservation of urban- rural, mainland- island differences in income, provision and in service delivery and the limitation of family related benefits (they are limited and from early 90's, focusing on women' job-family reconciliation) contribute to the maintenance of intergenerational dependence, specially in South Europe. At the same time, changes in the employment policies have a full impact on pension schemes, health insurance coverage and on health service provision.

Despite its increasing fluidity, the family remains the most important provider of welfare covering the lack of childcare services, and the mechanism through which resources are redistributed by filling in income gaps of first time jobseekers, elderly family members (with low minimum benefits). These facts are of vital importance for Greek social workers, who have to continue dealing with family oriented interventions.

In responce to unstable, vulnerable issues arising from the above transition, social workers adopt urgent, flexible, multifaceted interventions and advocacy.

The huge numbers of new, vulnerable consumers (immigrants, victims of trafficking) put pressure on professionals to arrange the existed limited resources, and further manage emergency and post-traumatic situations. Modern culturally pluralist societies where mayor task, there for is to built trust and rapport with consumers, who hold different views about health and illness, and who may perceive the professional helping systems as threatening or ineffective. Social workers have always respected different population cultures, and are aware that practice cannot be neutral, value free, or objective. Today they are multiculturally competent practitioners. They should get an awareness of general low and legal frameworks for different categories of service users and the legal aspects of care management.

As regards Welfare reform, from the early '80s, there has been a development in public-private partnerships and a greater involvement of voluntary organizations in service delivery. This reform drove to a reconstruction- marketization and to managed care, contractualization, where human ser-

vice delivery placed in the free market place. The health systems became very complex joining state and private services, NGOs, social enterprises, and profit-making companies. Medical equipment and pharmaceutical industries are major economic forces in health care provision. The increase in paternalistic practices and experts' power was an expected, negative impact of this evolution.

According to Gibelman, (2002:20) USA social workers working within health and human service organizations have had to learn quickly the business of managed care, including its technicalities, reimbursement requirements Their job descriptions mix sales, marketing and technology skills, clinical community practice and case management.

The landscape in, so called developed countries, is dominated by governments' central grip on benefit rates and saving rules and legislations, based on a faith of bureaucracy and uniformity. Responsibility has drained away from the welfare state and transferred to individuals. Emphasis is given to improvement of health attitudes, habits in personal and social level (corporal exercise, healthy feeding, avoid the starting of smoking, stay out of the path of HIV, violence and other pathogens).

In modern selfish societies, which persistently ignore the life conditions and health - mental health needs of the weakest and most vulnerable people, pluralist and cultural sensitive practice combining direct, social rights advocacy is urgent.

More over urgent is the valuable knowledge of crisis, post-traumatic processes and disaster management in order to apply social work under extreme social, economic, political and military circumstances, earthquakes and tsunami.

Research evidence on social inequalities and health

Extensive international epidemiological research demonstrates growing global inequalities in health and well-being and the social determinants of health, shaped by the distribution of money, power and resources at global, national and local levels. These social determinants are the conditions in which people are born, grow, live, work and age, including the health system, (WHO, 2007).

According to WHO's widely known national, international and yearly informed reports healthiness, disease, disability and death are seen to be the result of the interconnections between human biology, lifestyle, environmental- such as air pollution and access to clean water, and varied and hygienic food supplies- and social factors that can only be modified by direct health treatments (WHO, 2007).

Growing research evidence from fields of social policy clearly indicate that, education, poverty, geographic location and employment (Townsend & Davidson, 1982) and of the health systems even when they are universal (Petmezidou, 2006) are highly critical factors in the healthy life course.

The public health literature demonstrates that people who are disenfranchised, without power, in low socio-economic status or, in general, with life demands that outstrip their control, experience worse health status (Wallerstein, 1992). Countries with greater inequities between rich and poor have lower health status than countries with smaller income gaps (Evans et al, 1994, Kaplan et al, 1996). Differences in health status result from different living conditions, less access to nutritious foods, difficulty in finding decent housing or high-quality health care sensitive, low income, stressful and demoralizing work, punctuated by frequent periods of prolonged unemployment.

Inequalities in health status therefore, are the result of inequities in life and lack of social justice, can be considered a risk factor for disease.

Paying greater attention to the details of the relationship between social factors and physical and mental health, and acting towards social patterns and structures that shape people’s chances to be healthy challenge current social work practices.

A number of key issues is at the heart of both the international application of social work and its restructuring in each country. How can social work values operate in the existing social policy?, Methods are applicable to all kind of varieties and changing situations? How can practitioners develop new ways of working which are flexible and responsive? Who determines what service-users needs are, how are those needs met and services delivered? What is the relationship between social work and with NGOs and what is with the profit making organizations? Does the social welfare reform aims towards a temporally survival or to a well-being approach? Is the knowledge about the strong interrelation between people's health concept with their concept of the body integrated in practice? etc, etc.

Although the combination of poverty, illiteracy, exploitation, violence and injustice along with the lack of access to the existing health and social support is widely recognised, modern health systems do not take it into consideration.

The contemporary post-welfare state is a minimalist state encouraging inequality, privatization, competition, a belief in material incentives, and higher rewards for higher production and efficient management (Jamrozik, 2005). The resulting reconstruction or marketization of welfare has placed

service delivery in the free marketplace and made it open to pressures of profit margins, contractualization and managed care.

These challenges have forced professionals to pay extra attention, and make an effort, to remain committed to a code of ethics, addressing socially equitable distribution of resources and human worth and dignity, evaluating its own part in paternalistic and expert-power practices and supporting the growth of consumer rights movements.

Welfare rights advocacy, a traditional aspect of social work, helping people find a way through complex welfare systems remain important. As these systems are complex, and bureaucratic, helping patients to gain both general benefits (income support, housing benefit, council tax benefit) and entitlements arising from their serious illness (disability living allowance, carers allowance, attendance allowance and incapacity benefit), remains central to social work practice. According to J. Levy and M. Payne (2006, 330) chronically ill patients go well beyond an appropriate information, assisting them to make applications, acting on their behalf in negotiations with welfare services and, if necessary, appealing against decisions detrimental to and representing them at tribunals.

There is both substantial need for support patients in gaining benefits related to illnesses, and enabling them to use them successfully in favour of their own autonomy and dignity.

Developing opportunities to promote the principles of equality and human worth

The key word that brings together the concepts of health promotion and social justice is power. Lack of power in the individual, community and societal level is a major risk factor for poor health (Wallerstean and Freudenberg, 1998: 453). This suggests that disempowering those who use their privilege to benefit themselves at the expense of the well-being of the community is an important tool for health promotion (Freire, 1970).

Health promotion is defined as a comprehensive process of enabling people to increase control over, and improve their health. Emphasis is given to wellbeing and behavioural changes in exercise, diet, sexual behaviour, avoidance of drugs, alcohol and tobacco, and to environmental policies. Strategies for health, such as a healthy-public policy, supportive environments and community action, overlap substantially with the goals of social justice (Wallerstein, et al, 1998:451). Promoting health does not necessarily lead to more social justice, and promoting social justice may not improve health.

As discussed earlier, both social justice and health promotion strategies are intervention oriented. Attempting to change conditions and behaviours requires value equity and community mobilization to redistribute power and advocacy (Minkler, 1994). An important strategy is to engage people from diverse communities, to speak across differences, to share in each other perspectives and frustrations, to propose specific policy changes to encourage further participation in civic decision making and to celebrate the successes. According to Wallerstean and Freudenberg (1998: 456) "linking health promotion and social justice has the potential to mobilize powerful new constituencies for health".

Limited analysis of the poverty dimension of health limits the ways to seek about solutions. Social workers have to readdress and disseminate the combination of poverty with chronically illness, mental illness, child rejection and abuse, addictions and so on.

Social work discourse has to play a significant role in the changing of the dominant orientation by extensive criticism of hospital centrism, commercialization and fragmentation, and supporting their replacement by health equity, universal access to people-centred care and community health care. Moreover, by arguing the usefulness of a needs assessment perspective, prioritization of needs, and the effectiveness of implementing concrete measures, targeted actions and holistic approaches in all interventions.

Today the worldwide, neo-liberal trend towards restrictive welfare benefits requires citizens to reduce their dependence on the state and try to secure work rather than asserting their rights to benefits (Levy and Payne, 2006: 324). Social workers play an important role in securing the welfare rights of the service users and in raising their awareness of the social and psychological causes of mental and psychosomatic illness. To collaborate with other health professions in tackling mental and other illness stigma, a determined barrier to social inclusion, is an uphill task.

This neoliberal trend drives to the need of an indept knowledge of the socio-political situation, personal and social needs and ideologies. It also drives towards an adoption of holistic approaches, multidisciplinary working methods, and regular evaluation and review of service delivery in the context of changing needs and developments. An effective contribution to the decisions on appropriate referrals is based on a full knowledge of appropriate exploration of priorities in practice and of local

facilities and services. This leads to improved patient care and continuity of care in the long term and to prevent unnecessary admissions.

The deinstitutionalization processes demands communities' sensitization and education on patient's individual and social rights. According to K. Johnson (1998), "deinstitutionalization concerns social rights' management".

Local services must offer multidisciplinary assessment, treatment, rehabilitation and after care service for mentally disorder offenders. Social workers must ensure that patients have the same liberty, rights, autonomy and choice as any other member of the community. Also they ensure that service be delivered flexibly and comprehensively to respond to the individual needs of patients and that reports for outward referral and transfer are produced in good time.

Concluding remarks

Health and mental health social work has developed as a specialist area with a clear professional identity. It has moved from a medical to a health profession with a deep knowledge that health is a universal social right by name, as a result of the global impact of free market economies and the predominance of neo-liberal, neoconservative ideology. Its provision depends on given political-economic structures which identify / control both the conditions of life (causes) and access to the services (prevention, treatment, rehabilitation).

Most of the social work' acceptors have weak, exhausted or inadequate social networks, expecting help by clinical workers working in market-oriented services and delivery systems. People experiencing a disease or a breakdown deal with functional problems in all aspects of their life: at home, in child rearing, at work, at school, in friendship, in their neighbourhood, in the community, and social work is expected to meet a wide range of needs until their recover. Dealing with multi problematic situations demand knowledge and skills for short and long term, multifaceted approaches and holistic interventions.

Health, as all kinds of social resources, needs continuing care, and support in order to be renewed, updated and enlarged. There must always be an open question as to whether its provision keeps indisputable, doubtless, universal and of good quality. Social work contributes to this by developing all possible opportunities to promote the principles of equality and human worth in both education, practice and research.

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ЭКСПЕКТАЦИИ В СОЦИАЛЬНОЙ РАБОТЕ И ВМЕШАТЕЛЬСТВА В СФЕРЕ ЗДОРОВЬЯ

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Рассматриваются социальные факторы здоровья и роль социальной работы в развитии системы охраны здоровья с точки зрения различных социологических концепций. Особое внимание уделено состоянию системы здравоохранения в Греции как результату идеологических, демографических и политических процессов.

Ключевые слова: здоровье, здравоохранение, международный опыт социальной работы, социальная работа в Греции.