

Social work and public health – Logical collaborators

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This last year, our lives have been turned upside down by Covid-19 and the public health responses needed to keep our communities safe. Most of us probably had little awareness of public health before this. At the height of lockdown, and almost overnight, public health had become a topic of daily conversation; suddenly, everyone was talking about epidemiology, and disease modelling. The pandemic turned public health from obscurity into a focus of intense and life-saving relevance, taking public health professionals a bit by surprise; everyone from chief medical officers to epidemiologists were getting crash courses in media interviews and press conferences. Skilled health communicators such as Siouxie Wiles in Aotearoa New Zealand and Norman Swan in Australia became crucial interpreters for the wider community in the face of complex information about the pandemic. While many social workers may not know a lot about public health, either as a discipline or specialisation of medical practice, there are substantial points of connection with our profession—enough to consider that social work and public health are logical collaborators.

Some information about public health

Public health's origin story takes us back to another pandemic—that of cholera, in the late 19th century (Krieger & Birn, 1998)—a bacterial infection spread through contaminated food or water supply and often linked to poverty. During the 1854 Broad St outbreak in London, physician John Snow removed the handle of a public water supply pump and prevented access to the contaminated water supply. This

act created a powerful image of a simple social intervention that positively affected the health of the entire community by preventing disease. As with any origin story, there is a lot more detail, yet it is this image that captures something important about public health medicine.

Last April, public health researcher Louise Thornley authored an article titled “A beginner's guide to public health” (Thornley, 2020). As Thornley observes, public health is often behind the scenes and not at the adrenalin end of medical practice. This gap in knowledge made writing such a beginner's guide important. When we think of health, we often imagine doctors, nurses, and hospitals. In the broader health context, they are the ambulance at the bottom of the cliff—providing health care once something has gone wrong. Public health is poised at the top of the cliff to work out why people are falling off and then to work out what needs to be done to stop this. The pump handle story demonstrates how simple upstream actions to prevent the spread of disease can avert disaster by preventing whole communities from being exposed to disease. Such public and environmental measures benefit everyone; however, they specifically benefit poorer communities who have limited health alternatives.

Public health has developed as the social justice voice in medicine, focused on the influence of social conditions on health, both good health and illness. Public health research focuses on the links between systems, social conditions and inequities and poor health. It advocates addressing social and structural problems that contribute to disease and other health problems, including

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factors like poverty, poor housing, and discrimination, because these contribute to worse health outcomes and shorter life expectancies.

If this sounds familiar, there are good reasons for that. There are historical parallels between the origins of social work and public health in the progressive movements of 19th century United Kingdom, which also saw the rise of anti-slavery and women's emancipation movements. They occurred at a time when there was an increasing focus on the conditions of poverty and the negative impacts it had, not simply for individuals but for society as a whole. It included a focus on structural influences and moves away from blaming individual moral failure for poverty or illness. These threads come together in C Wright Mills' (1959) concept of the sociological imagination, which most of us would recognise as the connection between private troubles and public issues.

What significance does this have for social work?

Public health was already significant to social work, even before Covid-19 and the needed public health responses. We already engage with public health knowledge and concepts to talk about social work concerns, whether we are aware of the connection or not. Concepts like the social determinants of health, health promotion, and population health measurements of inequality and socioeconomic deprivation come from public health (Crampton et al., 2020). We draw on these knowledge sources in social work to understand population and structural issues affecting the people and communities we work with. Public health research has expertise in identifying influences on health from statistical analysis of population-level data and epidemiology. Population health studies create an important basis in evidence for the impacts of social and economic disadvantage, even though they are focused on only one aspect (health); their capabilities in statistical analysis add weight to the

social and economic benefits of reducing disadvantage, poverty, and inequality.

Public health's significant body of research on inequality and inequities constitute a major benefit for social work in the context of our shared concerns for the impact of these things in people's lives. While public health is more specifically focused on health outcomes, social work expands the view to consider how health can be both *outcome* and *influence* along with other social factors such as education, housing, occupation, and so on.

Some countries have more established links between social work and public health, including a recognised field of public health social work (Ruth et al., 2020). Here, professional practice brings the strengths of both discipline areas together to emphasise person AND population. Social workers in these contexts talk about the value of the broader perspective of social work for approaching public health work in relation to a grounding in interdisciplinary knowledge and specifically sociological theory. In Aotearoa New Zealand, explicit practice links between the disciplines have not been as strong despite the substantial synergies.

Public health and social work also share a vision of social justice: that individual suffering has societal influences that create and perpetuate inequities. This is strongly evident in public health research and advocacy, especially some of the great work done in Aotearoa New Zealand on housing (Baker et al., 2012; Howden-Chapman et al., 2007) and poverty (Carroll et al., 2011; D'Souza et al., 2008). Public health focuses or organises these specifically as health inequities while social work maintains a broader view of social inequities (which have consequences for health but also for other kinds of ills or social suffering).

Collaborating as a critical friend

So how might social work, in turn, be significant for public health? It could be

tempting to look at public health as a well-established and well-resourced discipline and feel that social work and social workers do not have so much to contribute. However, social work brings important strengths in its broader sociological, interdisciplinary, and transdisciplinary knowledge base that may not feature as strongly or deeply in public health. Social work's scope of practice and vision encompasses working with individuals through to communities and societal structures, where public health is commonly focused on the macro and population levels. Social work has a distinctive skill in maintaining that dual perspective. Social work is also actively engaged with communities on the ground in the doing of social work. In these respects, social work can be uniquely positioned to identify gaps and speak up for people who may be invisible in some population-level views and to provide a link with those communities. Social work was among the first global voices to challenge and reframe the public health term *social distancing* to *physical distancing*, *social solidarity*, thus highlighting the need to maintain social connectedness when people need to be physically separate (International Federation of Social Workers [IFSW], 2020). The vital role of sustaining social connection for mental and social health has been witnessed globally and repeatedly as communities have lived through successive lockdowns to control the virus spread.

To explore how collaboration with public health might work, I would like to introduce the notion of the *critical friend*. This concept had been developed in education and teaching practice as a component of reflexive practice. A critical friend is defined as "a trusted person who asks provocative questions, provides data for examination through an alternative lens, and offers critique as a friend" (Baskerville & Goldblatt, 2009, p. 207; see also Costa & Kallick, 1993; Hedges, 2010). While the term may be unfamiliar in the social work context, this description of what a critical friend does will be very familiar in its similarities to

practice supervision. We might understand a collaboration between social work and public health relative to critical friendship as a parallel to the work of a critical friend between individuals. Vital to such a collaboration are acknowledging strengths and wanting to help with moving forward. The *critical* stands in an analytic rather than a destructive sense. The purpose of a critical friend is to identify strengths and to encourage as well as pose questions and present other perspectives. The intent of these activities is to support moving forward.

One of the key functions of a critical friend is to identify gaps that might only be seen through an alternate lens. Social work as a discipline and profession has expertise in looking for the gaps. Under-recognised gaps in public health responses have been a consistent feature of Covid-19 outbreaks internationally, and often linked with social disadvantage, marginalised communities, and structural brittleness. We have seen examples of these gaps in the disproportionate effects on people in low-paid and often precarious casual work who cannot work from home or afford to isolate after testing. A specific instance worldwide has occurred in the context of residential aged care—a sector commonly dependent on a low-paid, casualised workforce, frequently working across several institutions in order to cobble together enough hours for a basic level of income. These social conditions have contributed to difficulties managing outbreaks in many countries and specifically affect migrant, First Nations, and communities of colour, where racism and colonisation have exacerbated problems (Büyüm et al., 2020). The unrecognised gap of conditions in migrant worker dormitories was a driver behind the secondary outbreak in Singapore. Privacy and surveillance concerns have been raised related to tracking app technology and automated data-gathering by governments, notably where there is low trust about data linking and a lack of clarity about future use to target individuals (Kang & Haskell-Dowland, 2020). Other examples

in our region include descriptions of the August outbreak in Auckland, identified as “South Auckland”—which is often read as code for Māori or Pasifika (especially in parallel with the categories *factory work* or *large families*). Similarly, during the Victorian second wave, mention of specific suburbs known to be places where there are significant migrant communities contributed to fears in those communities and reticence to get tested. Identifying and changing stigmatising language is a vital intervention to support marginalised communities to engage with public health work and to avoid discrimination in public messages. Social work is well positioned to identify such discursive elements and advocate for greater care in public health communications.

It remains vital to acknowledge that public health, like social work, exists as part of coloniser structures (Büyüm et al., 2020). That structural context and the types of emergency powers that can be invoked under the Public Health Act require accountability to Māori, Pasifika, and other marginalised communities in the actions undertaken and their impact. Social work and public health share murky histories of anachronistic paternalism when it comes to social control (Ashton, 1988). There has been work in public health which parallels social work’s efforts to adopt more collaborative ways of working with First Nations people, even if it is yet to tackle decolonisation. However, the risks of colonial paternalism remain, especially in high stress situations combined with statutory powers. Lockdown measures have affected marginalised communities to a greater extent and in ways that we are still only beginning to understand.

Self-determination for First Nations communities has been one of the shining stars in the pandemic response and creates the strongest case for giving over both control and resource as a longer-term structural shift (Marwung Walsh & Rademaker, 2020). Early in the pandemic, there was significant concern in public

health about poorer health in First Nations communities worldwide and the implications for devastating death rates in the event of Covid-19 infection arising from the impact of past pandemics (Crooks et al., 2020). This time, communities and Aboriginal controlled health services were given control over both prevention and response. Remote communities in Australia have been an exemplar, where Aboriginal leadership took charge, made the decision themselves to close communities, and produced clear and unambiguous health information in appropriate language (Finlay & Wenitong, 2020). As a result, the usual gap between First Nations health and the general population has been reversed precisely because the response started with listening to communities and handing over control of the response (Silva, 2020). The challenge now for public health and policy is to build on this early success and address the long-standing structural vulnerabilities for these communities (Fitts et al., 2020).

Systemic issues are beyond the capacity of a disaster response, for either public health or social work. However, public health responses have highlighted in stark terms the impact of social structures and economic decisions on health for communities as well as individuals. Social work’s familiarity with the communities we work in and alertness to structural disadvantage give us an important foundation to work with public health as a critical friend, to keep them and ourselves accountable, and to move us all forward in pursuit of social justice.

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