Chapter

Mitigating Health Inequalities of Socially Vulnerable in South Korea: Role for Social Work

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Abstract

The purpose of this study is to develop a social work education strategy for mitigating health inequalities among the socially vulnerable. The limitations of the healthcare approach to health promotion and health inequality, which we examined through the health belief model describing an individual's health behavior, emphasize the prevention of diseases that have not yet occurred or are likely to occur, healthcare management for them, and the functions and role of the community in the process, based on the individual's spontaneity to practice health behaviors. Therefore, to compensate for these limitations, it is deemed necessary to add healthcare curriculum, such as public health, social epidemiology, and etiology, to the existing curriculum of social work based on an in-depth understanding of social vulnerability and social environment as well as the importance of preventing and managing diseases.

Keywords: social work, healthcare, health belief model, health inequality, socially vulnerable

1. Introduction

The rapid development of capitalism due to industrialization has improved socioeconomic levels around the world as well as increased the nation's interest in the level of people's health. The concept of health inequality that emerged from this process has served as an opportunity to establish and implement healthcare policies based on it, along with increasing global interest in the relationship between health and socioeconomic inequalities since the 1980s.

Although the concept of health inequality varies from scholar to scholar, the concepts of Whitehead [1] and the International Society for Equity in Health (2002) are generally used. According to Whitehead [1], "Inequality in health is a term commonly used in some countries to indicate systematic, avoidable and important differences" [1]. On the other hand, according to the definition by the International Society for Equity in Health, health inequality is "The absence of systematic and potentially remediable differences in one or more aspects of health across populations of population subgroups defined socially, economically, demographically, or geographically" [2]. In other words, health differences or gaps among individuals or groups can be caused by various socioeconomic factors, such as income, occupation, education, gender, and residential areas, in addition to the biological characteristics of individuals.

This view of health gradually spread to European countries in the 1990s, and in 2008, the World Health Organization published "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health," which emphasized that the issue of health inequality should be addressed as a worldwide issue, and developed a strategic interest in healthcare policies and policies based on the current state of health inequality around the world [3–5]. Through these efforts, some countries have achieved partial reductions in health inequality problems, such as maternal-infant mortality [6], child and family health [7], and non-inflammatory diseases [8]. However, despite various efforts and attempts by the healthcare sectors of the world, the problem of health inequality seems to persist [9–11].

On the other hand, considering that the issue of health inequality is mainly a social problem experienced by the socially vulnerable, understanding social work that targets them is believed to provide insight into alleviating health inequalities. In modern society, social vulnerability generally means a group of individuals or such individuals who are excluded, marginalized, or left behind in a capitalist economic system [12]. Therefore, social work strategies for them are focused on socioeconomic support to address or alleviate their current difficulties by direct and continuous interaction with individuals or groups or various training and support programs for re-entry into a capitalist economy. In other words, in addition to direct and indirect support through various policies, support is needed in other community-based ways through direct and continuous relations with the socially vulnerable.

Therefore, in this study, we would like to consider the role of social work to complement the limitations healthcare approaches in order to mitigate the problem of health inequality among the socially vulnerable.

2. Methodology

In this study, we would like to explore the limitations of the existing healthcare approach to health inequality of socially vulnerable group through a literature review and present the role of social work to complement it. To that end, we will first look at the WHO's view of health and its transformation process. This is because it has a huge impact on health-related policies of individual countries by forming healthcare paradigms.

On the other hand, the key to healthcare policies is to encourage an individual to practice health behaviors to maintain or enhance their current health [13]. In the case of South Korea, various efforts have been made to reduce disparity in the 3rd Health Plan 2011–2020 that includes smoking, high-risk drinking, physical activity, and prevalence of obesity and hypertension as indicators to address health inequality based on income levels [14]. The results showed that the gap between the smoking rate and the high-risk drinking rate has somewhat eased, but the gap has widened for the physical activity rate and obesity rate [14]. Based on this, a healthcare approach alone is difficult to induce individuals to practice their health behaviors. Therefore, we would like to explore the theories involved in order to understand the health behaviors of individuals.

3. A healthcare perspective on health

In 1978, the WHO set all human health goals as the attainment by "all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" [15] and began to discuss in earnest the

need for the Alma-Ata Declaration, which centers on the activation of primary healthcare as well as intersectoral collaboration at various levels of society to address health inequalities [16]. The concept of health promotion, which began to be emphasized during this process, started to be perceived as a new strategy to realize people's social responsibility for a healthy future by arbitrating or mediating between individuals and the environment surrounding them [16].

As health promotion was being highlighted as a new approach to healthcare, the traditional approach to healthcare that centered on the treatment of diseases in the past began to change to prevention of diseases [13, 16]. Based on this paradigm shift, the WHO and its members held the first International Conference on Health Promotion in Ottawa, Canada, in November 1986 to establish and publish the Ottawa Charter for Health Promotion [17]. In the Ottawa Charter, health promotion is defined as a process that allows people to control and manage their health and health determinants, thereby improving their health. It presents three approach strategies to realize health promotion: "Advocate," "Enable," and "Mediate" as well as the five main areas of activity: "Build healthy public policy," "Create supportive environments," "Strengthen community actions," "Develop personal skills," and "Reorient health services" [17]. The Ottawa charter lays the groundwork for efforts to promote health in all the countries around the world, even today, more than 30 years later [16]. The WHO has since held a world conference on health promotion to reconfirm the basic principles and methodologies of health promotion, and through continuous discussion, it seeks effective and sustainable health promotion approaches to address health issues that are newly encountered with global environments, such as lifestyle and environment changes due to the development of globalization and information and communication technology [16, 18].

Conversely, this shift in the healthcare paradigm, centered on health promotion, also represents a shift from the past paradigm centered on the treatment of acute diseases to a paradigm centered on the prevention and management of chronic diseases [13]. This means that the problems of health inequalities experienced by the socially vulnerable today persist in a paradigm centered on the prevention and management of chronic diseases. So, despite these efforts by the healthcare sector, why does the phenomenon of health inequality persist? To this end, the following section looks at the health belief model, a theoretical framework that describes an individual's health behavior.

4. Health belief model

As national interest in health increased from the 1970s, various models and theories were proposed to predict and explain individual health behaviors. The health belief model describes health behaviors based on individuals' belief in perceived susceptibility, severity, benefits, and barriers to disease [19, 20]. The theory of rational behavior and the theory of planned behavior described health behaviors under the assumption that individuals use relevant information reasonably and systematically before doing anything [21, 22]. The precaution adoption process model explains that individuals go through seven stages of unaware of issue, unengaged by issue, deciding about acting, decided to act, acting, and maintenance until they act to protect their health [23]. On the other hand, the health belief model emphasizes aspects of subjective judgments for individuals to practice health behaviors. However, in contrast, other theories highlight the systematic collection and interpretation of health-related information for subjective judgments of individuals, opinions of others, and the process of decision-making based on it [21–23]. However, considering that the characteristic of the socially vulnerable

group can have a negative impact on the process itself of establishing a basis for subjective judgment, it is considered to be somewhat difficult to explain their health behaviors. Therefore, this study focuses on the health belief model.

The health belief model is a theoretical model developed in the early 1950s by social psychologists from the United States Public Health Service to explain the poorly examined phenomenon of disease prevention or early detection of diseases with no symptoms [19, 20]. Health belief models were subsequently studied by various scholars [20, 24–26], of which Janz and Becker [20] presented the following components of health behavior practice for individuals to prevent and manage diseases.

4.1 Perceived susceptibility

Perceived susceptibility refers to subjective judgments about how much one is exposed to health-threatening factors [20]. For example, the women who think they are less likely to have breast cancer [24, 26].

4.2 Perceived severity

Perceived severity refers to subjective judgments about how dangerous and serious the factors that threaten one's health or the consequences resulting from a disease are [20]. For example, women who believe that mortality increases without breast cancer screening are more likely to perform breast cancer screening [24, 26]. On the other hand, a combination of perceived susceptibility and perceived severity creates perceived threat, which is an influencing factor for predicting health behavior [25].

4.3 Perceived benefit

Perceived benefits refer to subjective judgments on the benefits of the following recommended actions [20]. The more positively a person evaluates the benefits of a health action, the less likely the threat is perceived. For example, a person who thinks that breast cancer screening is more accurate is more likely to go for a checkup than someone who thinks it is less accurate [24, 26].

4.4 Perceived barriers

Perceived barriers mean subjective judgments on the cost, time, and emotions in performing recommended actions [20]. Some people who do not undergo breast cancer screening acknowledge the benefits of the examination but do not act out of fear of the cost and time-consuming examination process [24, 26]. On the other hand, perceived benefits and perceived barriers have a direct effect on health behavior, unlike the two factors discussed earlier [20].

4.5 Cue to action

Cue to action refers to an internal or external stimulus that motivates an individual to perform their own health actions. In this case, internal cues refer to the self-awareness of the symptoms of one's health condition, and external cues refer to the messages sent through the media or by health experts [20]. These behavioral cues increase perceived susceptibility and perceived severity, thus, increasing the intention of action [20].

In addition to the five factors discussed earlier, the health belief model includes perceived threat or demographic/social psychological variables that can affect a

person's health behavior, which provide a direct or indirect incentive to practice health behavior, either individually or by a combination of each factor.

5. Limitations of the healthcare approach to health inequalities among the socially vulnerable

5.1 Paradigm shift from treatment to prevention: emphasis on prevention

As we saw earlier, the approach to health from a healthcare perspective can be seen as an emphasis on the prevention paradigm, namely the formation of conditions that enable control and management of individuals' health and health determinants through the concept of health promotion centered on disease prevention and management. However, based on the view of the health belief model that describes an individual's practice of health behavior, the approach from a healthcare perspective emphasizes prevention of future illnesses and their healthcare management. The limitation of this approach, however, is that while it may increase the likelihood of screening an individual for disease prevention or healthcare, it does not enforce the practice of actual health behaviors. This means that based on perceived health risk factors, the final decision of whether an individual will practice healthy behavior or not is entirely their own [27, 28]. Moreover, given that the problem of health inequality is mainly a social problem experienced by the socially vulnerable, their diverse characteristics [12], such as low socioeconomic status and educational levels, are such that even if they have recognized factors that can negatively affect their health, they are not limited to leading to various tests for disease prevention or implementation of health behaviors for health management.

Therefore, if we look at the phenomenon of health inequality among the socially vulnerable today based on the health belief model, we can think of the healthcare approach that emphasizes the prevention of health inequalities as an approach that reveals its limitations at the point where, despite various efforts and attempts to resolve issues, it leads to health management practices for the prevention of diseases among individuals belonging to socially vulnerable groups. The above is illustrated in **Figure 1**.

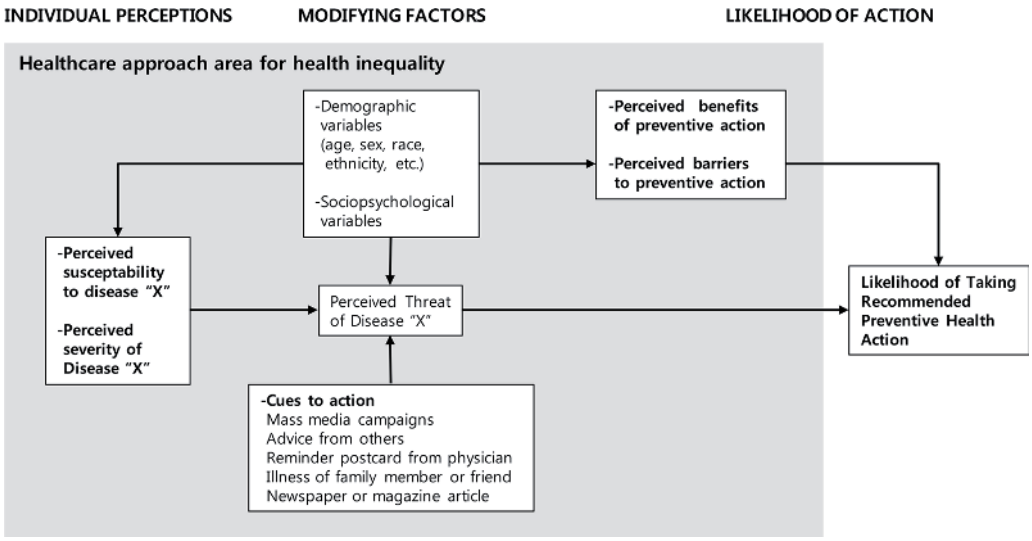

Figure 1.
Basic elements of the health belief model (Janz and Becker [20]). Note: part of the figure has been modified to aid understanding of this study.

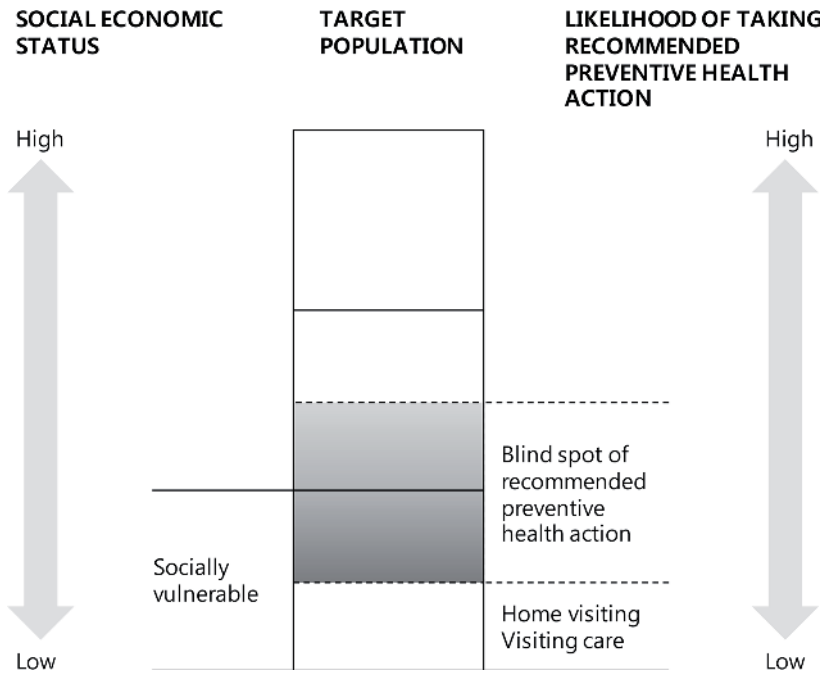

Figure 2.
Blind spot of recommended preventive health action.

Of course, in order to cope with these problems, the government provides various healthcare services for the socially vulnerable, such as medical examinations, visiting care, and home visits, but the related resources are insufficient to cover all aspects of social vulnerability. This is also why communities emphasize on health promotion policies. Thus, the phenomenon of a prevention-oriented healthcare paradigm that emphasizes individual spontaneity for health promotion and a lack of healthcare resources to directly intervene in the practice of individual health behaviors can form a blind spot for the target population (**Figure 2**). Furthermore, such a blind spot regarding healthcare policy can be considered as a major factor for sustaining the phenomenon of health inequality among the socially vulnerable, despite various attempts and efforts to address this issue.

5.2 Lack of understanding of the community: is the community a modern elixir?

The Ottawa Charter, which produced a global consensus on basic strategies and areas of activity for the promotion of health, places specific emphasis on the role of communities in the process of prioritizing, deciding, planning, and carrying out health promotion activities to improve people's health level [17]. Further, the key functions and roles of the community for the promotion of health are to establish a system of related services for improving the health of local residents as well as to encourage active participation by the general public and local residents in local health-related issues and to enhance their ability to address them [16, 17]. On the other hand, the emphasis on communities here is that individuals and families are part of the community [29], that the healthcare paradigm from a past therapeutic perspective has not done much to address the adverse health phenomenon [30], and that health promotion requires collaborative approaches to various areas besides the healthcare sector [31]. Then, what does a community mean? There are many different views of the community, including:

First, to view the community as a unit of political collective action. From this point of view, local communities exist everywhere and proximity to various

activities in daily life is seen as a place where the majority of the members can have political will [32].

Second, to view communities as functional units of production and exchange. The community is an activity space with a concentration of various social functions, including the production and use of social and commercial goods and services, socialization processes, social control mechanisms, opportunities for social participation and civic engagement, and access to mutual assistance [33].

Third, to view the community as a network of relationships or a structure of interaction between individuals. This view highlights two aspects. First, the intimate relationships, the degree to which you let people you know to know you [34, 35]. The other concerns the extent of the relationship, that is, the possibility of being connected to the network of relationships held by others beyond the scope of the community at the administrative district and the possibility of accessing various information, resources, and opportunities beyond the adjacent networks [36–38]. Based on the above, communities and its various possibilities could be considered as an elixir in modern society [39].

On the other hand, the variety of possibilities that communities have means that in order to function as an elixir for the health promotion or address health inequality of local residents, they must be perceived as a concrete object, like a social problem, that can be addressed more specifically. In general, social problems mean that it becomes visible as a social phenomenon [40] or the social condition in which people perceive it as a serious problem and want to improve it [41]. However, as mentioned earlier, the prevention-oriented approach mainly addresses health-related issues that have not yet occurred or are expected to occur in the future, so it can be seen as exposing the limitations of using various resources in the community to enhance the participation and capacity of local residents and to encourage active implementation of individuals' health behaviors. Additionally, such a limit can be considered as another factor that escalates the phenomenon of health inequality, especially among the socially vulnerable.

6. Educational strategies of social work to mitigate health inequalities among the socially vulnerable

Traditionally, social work is primarily targeted at socially vulnerable groups, individuals experiencing exclusion, alienation, or rejection due to lack of productive forces in the capitalist economy. Then, what kind of educational content does the social work that targets them highlight?

The International Association of Schools of Social Work (ISSW) and the International Federation of Social Workers (IFSW) adopted global standards for education and training of the social work profession through a general meeting held at Adelaide, Australia, in October 2004. The content of the standards to core curricula presented here suggests that students majoring in social work experience four core curriculums [42]:

The first area is the "Domain of the Social Work Profession," which includes the effects of socio-structural inadequacies; discrimination; oppression; social, economic, and political injustices on human functioning and development; knowledge of human behavior and development and of the social environment; critical understanding of the origins and purpose of social work; and the effects of social stability, harmony, interdependence, and collective solidarity on human development [42]. The second area is the "Domain of the Social Work Professional" that includes the development of self-reflective practitioner, the recognition of personal value systems, the recognition of ethical provisions, and sensitivity

based on diversity and their ability to address them [42]. The third area focusses on the "Methods of Social Work Practice," which include assessment, formation of relationships and aid processes, value, ethical principles, application of knowledge and skills, social work research and skills, and field training [42]. The last area is the "Paradigm of the Social Work Profession," which includes human dignity and values, advocacy, empowerment, respect for the rights of service users, tasks and crises along the life cycle, recognition of strengths and potential, respect and recognition of diversity [42].

Considering the above, the general social work education strategy can be thought of as a strategy that focuses on various areas, such as basic development process and socioeconomic support that can affect them through direct and indirect intervention and psychological support for re-entry into the capitalist economy, based on an in-depth understanding of individuals and families or specific groups. One point to be noted here is that the healthcare sector was not included, although social work has specified access to and involvement in various areas that affect their vulnerability as a core curriculum. Based on this, the academic boundaries [43] can be expected to exist, emphasizing healthcare centered on disease prevention and treatment and social work centered on social and psychological support for re-entry into the capitalist economic system. Furthermore, such academic boundaries also mean that healthcare issues, including various social factors, such as health promotion or health inequalities, simply approach health and medical issues in the same way as a team approaches, that does not help much in solving problems [44].

As we saw earlier, the limitations of the healthcare approach to reduce health inequalities have been found in the prevention-oriented policy keynote and lack of understanding of the function and role of the community, which presupposes the willingness of individuals to practice health behaviors. Further, the limitations of this approach to the phenomenon of health inequality can be considered as a factor that continues to this day, despite the various efforts and attempts in the past four decades to resolve it. Therefore, to overcome these limitations, it is deemed necessary to add healthcare-related subjects, such as public health or social epidemiology and etiology to the existing curriculum of social work, which are based on a deep understanding of the social environment and the human nature. Moreover, given that the issue of health inequality is a social problem experienced by the socially vulnerable, the main target of social work, the motivation and monitoring of these people to implement and maintain health behaviors and the possibility of improving the environment of the community and organizing related community resources through social problems can be found in the aforementioned academic and practical features of social work. This, in turn, can be expected to compensate for the limitations of the healthcare approach to reduce the health inequalities that the socially vulnerable experience.

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Conflict of interest

The authors declare no conflict of interest.

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