CATHOLIC HEALTH
Australia

Level 1, 10 Thesiger Court
DEAKIN ACT 2600

PO BOX 330
DEAKIN WEST ACT 2600

Ph +61 2 6203 2777

Fax +61 2 6260 5486

www.cha.org.au

3 January 2012

Dr Ian Holland
Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Dr Holland

Inquiry into Australia's domestic response to the World Health Organization's Commission on Social Determinants of Health report "Closing the gap within a generation"

In appearing before the Inquiry during its hearings in Melbourne on 4 December 2012, I was asked to consider five questions on notice. I provide below and by way of attachment responses to those five questions.

Question 1: What is the effectiveness of public health marketing campaigns in improving health outcomes of people of low socioeconomic status (SES)?

During the Inquiry hearings, the role of health marketing campaigns and their benefit to low SES groups was considered. Catholic Health Australia (CHA) argues that health marketing campaigns have a role in managing population health, but that such campaigns are not always impactful with low SES groups and that action on social determinants of health and direct personal interaction should form part of improving the health of low SES groups.

The effectiveness of public health marketing campaigns within low SES communities is questioned by international peer reviewed literature. The following three studies illustrate doubt about the effectiveness of marketing campaigns in improving health outcomes for people of low SES. The consequence of this evidence for the Inquiry, and for the way in which governments and non-government organisations conduct public health marketing campaigns in Australia, is that efforts to improve the health of low SES communities are not best addressed through traditional health marketing campaigns.

Study 1: **"**Media campaigns to promote smoking cessation among socioeconomically disadvantaged populations"

"A systematic review of the literature on the effectiveness of media campaigns to promote smoking cessation among low SES populations in the USA and countries with comparable political systems and demographic profiles such as Canada, Australia and Western European nations… reviewed 29 articles, summarizing results from 18 studies, which made explicit statistical comparisons of media

campaign effectiveness by SES, and 21 articles, summarizing results from 13 studies, which assessed the effectiveness of media campaigns targeted specifically to low SES populations…found considerable evidence that media campaigns to promote smoking cessation are often less effective… among socioeconomically disadvantaged populations relative to more advantaged populations..(and that)… *Disparities in the effectiveness of media campaigns between SES groups may occur at any of three stages: differences in meaningful exposure, differences in motivational response, or differences in opportunity to sustain long-term cessation."*

(Reference: Niederdeppe, J., Kuang, X., Crock, B., Skelton, A., (2008), *Media campaigns to promote smoking cessation among socioeconomically disadvantaged populations: What do we know, what do we need to learn, and what should we do now?,* Social Science & Medicine, Volume 67, Issue 9, Pages 1343-1355).

Study 2: "Theory and Practice in Health Communication Campaigns"

A study reviewing the main theories of health communication found *"low socioeconomic status groups, which face the greatest threats of ill health, fail to benefit equally from campaigns compared to higher socioeconomic groups. The at-risk populations are most often left behind while campaigns continue to benefit the rich; a substantive body of evidence on knowledge gap theory points out that health communication campaigns contribute to the existing gaps between the rich and the poor."*

(Reference: Dutta-Bergman, M,. (2005): *Theory and Practice in Health Communication Campaigns: A Critical Interrogation*, Health Communication, 18:2,103-122).

Study 3**: "**Socioeconomic variation in recall and perceived effectiveness of campaign advertisements to promote smoking cessation"

"A survey involving over 7000 adult smokers conducted between 2007 and 2009 assessed SES variation in response to smoking cessation ads. Smokers with low levels of education and income less often recalled ads focused on how to quit, and perceived them as less effective."

(Reference: Niederdeppe, J., Farrelly, M., Nonnemaker, J., Davis, K., Wagner, L., (2011), *Socioeconomic variation in recall and perceived effectiveness of campaign advertisements to promote smoking cessation,* Social Science & Medicine, Volume 72, Issue 5, Pages 773-780).

Question 2: What support is there for the claim that the inclusion of a healthy food option on a menu leads to an unhealthy decision?

During the Inquiry hearings, the role of healthy diet campaigns and their benefit to low SES groups was considered. CHA argues healthy diet campaigns have a role in managing population health, but that campaigns have not to date always been impactful.

A survey of food consumption *"examined how consumers' food choices differ when healthy items are included in a choice set compared with when they are not available. Results demonstrate that individuals are, ironically, more likely to make indulgent food choices when a healthy item is available compared to when it is not available … Support is found for a goal-activation-based explanation for*

these findings, whereby the mere presence of the healthy food option vicariously fulfills nutrition-related goals and provides consumers with a license to indulge."

(Reference: Wilcox, K., Vallen, B., Block, L., & Fitzsimmons, J., (2009), *Vicarious Goal Fulfillment: When the Mere Presence of a Healthy Option Leads to an Ironically Indulgent Decision,* Journal of Consumer Research, Vol 36, Pages 380-393).

The relevance of this evidence to the Inquiry, and the way in which governments and non-government organisations promote healthy diets and eating, is that mere promotion of healthy food options is not necessarily the best means of ensuring healthy food consumption.

Question 3: What is the potential for the National Health Performance Authority to play a role in monitoring social determinants of health and their impact on the formal health care system?

CHA's proposal to the Inquiry is that the Department of Prime Minister and Cabinet should coordinate existing government instrumentalities in preparing an annual report to be delivered by the Prime Minister to the Parliament detailing health inequalities within the Australian population and actions that can be taken beyond the boundaries of the existing health system to improve the health of all Australians.

Within such a framework, there exists a role for the National Health Performance Authority. The Authority's strategic plan states its key deliverable is to *"publish reports on a quarterly basis on matters relating to the performance of local hospital networks, public and private hospitals, primary health care organisations, and other bodies that provide healthcare services."* It is conceivable that the Authority could within the auspice of this current plan develop protocols in order to report quarterly on data gathered from:

- Local hospital networks and public hospitals on consumption of hospital services by people from different SES groups to detail links between hospitalisation and SES to inform future efforts to avoid hospitalisation where social determinants are found to play a role in hospital admission;
- Primary health care organisations or Medicare Locals on social factors contributing to avoidable illness of people presenting to primary health care services. This could be enabled by way of doctors in general practice screening for poverty as occurs in Ontario (as demonstrated by way of Attachment 1, which is a poverty screening tool for use in general practice).

These quarterly reports could in turn be utilised by the Department of Prime Minister and Cabinet in preparing annual statements to be presented to the Parliament.

Whilst such reporting is conceivable, CHA recognises that this type of reporting was not foreseen by the creators of the Authority, and that such reporting is not central to the current three year work plan of the Authority. To this end, on 31 May 2012 together with colleagues I met with representatives of the Authority proposing a social determinants reporting role for the Authority, and I wrote that same day to the Authority proposing such a course of action.

To task the Authority to undertake work in reporting on social determinants, the Inquiry should as part of its recommendations:

- propose a role for the Authority in assessing the consequence of inaction on social determinants within the hospital system; and
- propose that Medicare Locals provide data to the Authority on those local social factors that contribute to avoidable illness;

in order for this data to form part of an annual Prime Minister's social determinants report to the Parliament.

Question 4: What is the purpose and location of the St John of God Raphael Centres?

During the Inquiry hearings, the role of acute hospitals in addressing the social determinants of health was considered, as was the role of Catholic hospitals in providing social outreach services aimed at addressing the social determinants of health. The Inquiry heard evidence from CHA Board Member and Chief Executive of St Vincent's Health Australia, Dr Tracey Batten, about the non-hospital services provided by St Vincent's Health Australia. In addition, I cited the St John of God Raphael Centres as an illustration of another non-hospital service provided by Catholic hospitals to address the social determinants of health.

By way of explanation, the St John of God Raphael Centres provide support and services to parents and families affected by anxiety, stress, or depression during pregnancy and following childbirth. Building on St John of God Health Care's expertise in maternity services, Raphael Centres offer mental health care to families from conception until the child is four years of age. Staffed by mental health clinicians, Raphael Centres provide a range of specialised services for individuals and families where the parent is experiencing a mental health disorder or where there are parent-infant relationship issues. Raphael Centres are fully funded by St John of God Health Care and welcome clients from all communities and all cultural backgrounds free of charge or at minimal cost. Raphael Centres are currently located across three states:

- New South Wales: Raphael Centre Blacktown;
- Victoria: Raphael House Ballarat; Raphael Centre Bendigo; Raphael Centre Berwick; Raphael Centre Geelong; Raphael Centre Warrnambool ;
- Western Australia: Raphael Centre Murdoch; Raphael Centre Subiaco; Raphael Centre Freemantle.

Question 5: Can you table the Norwegian Directorate of Health's report on measures to reduce social inequalities in health?

Provided as Annexure 1 is the Norwegian Directorate of Health's report on measures to reduce social inequalities in health. The report utilises six "intervention areas" aiming to improve social determinants for all Norwegians:

1. Income
2. Childhood conditions
3. Work and working environment
4. Health behaviour
5. Health services
6. Social Inclusion

Since the publication of this report, Norway has adopted a new Public Health Act that commenced operation in 1 January 2012, a summary of which is provided as Attachment 1. The Act recognises that both the national and municipal governments, and each of their agencies, all play roles in ensuring the public health of Norwegians, and that social determinants are key to good health and long lives.

Scotland in late December 2012 released an Audit Scotland report which found overall health in Scotland had improved in the past 50 years, but there were still deep-seated inequalities, largely because of poverty. Scottish Chief Medical Officer Sir Harry Burns responded to the Audit Scotland report saying life expectancy gaps between poor and rich could not be solved by the National Health Service alone, and more effort was needed on social factors that exist outside of the health care system.

Denmark has also adopted a reporting framework for action on social determinants. In May 2011, the report "Health Inequality: determinants and policies" was adopted by the Danish Minister of Health, Mr Bertel Harder, who committed Denmark to an action plan built on the following twelve principles:

Early determinants that affect social position and health

1. Early childhood development – cognitive, emotional, social
2. Schooling – school completion
3. Segregation and the local community

Determinants of illness influenced by social position

4. Income – poverty
5. Longstanding unemployment
6. Social marginalisation
7. Physical environment
8. Work environment – ergonomic and psychosocial
9. Health behaviour
10. Early functional decline

Determinants generating unequal consequences of illness

11. Health services utilization
12. The exclusionary labour market

As detailed in CHA's initial submission to the Inquiry, Sweden has also utilised a social determinants of health approach for near to a decade, having legislated a set of social determinant principles for its public health policy on 2003. Of interest to the Inquiry might be the conference to be held by the Swedish National Institute for Public Health in Stockholm on May 13-14 2013 titled "Sweden and the world: 10 years of a health determinants-based national public health policy." Attachment 2 is a brochure detailing the agenda for this conference.

The relevance to this Inquiry of this information about Norwegian, Scottish, Danish, and Swedish legislation and reporting frameworks on social determinants is that the governments of these

countries have each in recent year's recognised differences in health status and life expectancies of people of low and high SES. These governments have recognised improving health status and life expectancy required action outside of the health care system, and that monitoring, reporting, and action frameworks on social determinants were necessary. Australia has similar gaps in health status and life expectancy of low and high SES populations, and would benefit from similar monitoring, reporting, and action frameworks based on the World Health Organisation social determinants framework.

Summary

To summarise the recommendations that the Inquiry might make as a result of the detail provided to questions on notice:

1. Future public health marketing campaigns should be designed in response to evidence that they do not always impact the health of people of low SES, and that ideally the health of low SES people could be best improved by action on social factors that influence their health status.

2. The National Health Performance Authority should gather social determinants data from both local hospital networks and primary health care organisations, and that Medicare Locals in particular should engage general practitioners in a health screening program for the presence and consequences of poverty.

3. That the Prime Minister's Department review the Norwegian, Scottish, Danish, and Swedish social determinants reporting frameworks as part of the task in designing an annual social determinants report for the Prime Minister to present to the Parliament.

I trust the information provided in this response assists the Inquiry in its deliberations. I would be happy to provide any further assistance that the Inquiry might seek.

Yours sincerely

Martin Laverty
Chief Executive Officer

Attachment 1: Ontario General Practice Poverty Screening Tool
Attachment 2: Summary of Norwegian Public Health Act
Attachment 3: Swedish National Institute for Public Health Conference
Annexure 1: Norwegian Directorate of Health's report on reducing social inequalities in health

Attachment 1: Ontario General Practice Poverty Screening Tool

May 2012

Poverty Interventions for Family Physicians

POVERTY:

A clinical tool for primary care in Ontario

Poverty requires intervention like other major health risks: The evidence shows poverty to be a risk to health equivalent to hypertension, high cholesterol, and smoking. We devote significant energy and resources to treating these health issues. Should we treat poverty like any equivalent health condition?

Of course.

"There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health."

- Public Health Agency of Canada

Poverty accounts for 24% of person years of life lost in Canada (second only to 30% for neoplasms).

Income is a factor in the health of all but our richest patients.

Ontario College of Family Physicians

Family & Community Medicine
UNIVERSITY OF TORONTO

Three ways to address poverty in primary care: 123

1. SCREEN

Poverty is not always apparent... we can't make assumptions

Poverty is everywhere ... In Ontario 20% of families live in Poverty.

Poverty affects health on a gradient: There is no health poverty line. Income negatively affects the health of all but the highest income patients.

Screen everyone!!!

"Do you ever have difficulty making ends meet at the end of the month?"

(Sensitivity 98%, Specificity 64% for living below the poverty line)

2. ADJUST RISK

Factor poverty into clinical decision-making like other risk factors. Consider the evidence:

Cardiovascular disease:

- Prevalence: **17% higher** rate of circulatory conditions among lowest income quintile than Canadian average.
- Mortality: If everyone had the premature mortality rates of the highest income quintile there would be **21%** fewer premature deaths per year due to CVD.

Diabetes:

- Prevalence: Lowest income quintile **more than double** highest income (10% vs. 5% in men, 8% vs. 3% in women).
- Mortality: Women **70% higher** (17 vs. 10/105); men **58% higher** (27 vs. 17/105).

Mental Illness

- Prevalence: Consistent relationship between low SES and mental illness, e.g. depression **58% higher** below the poverty line than the Canadian average.
- Suicide: Attempt rate of people on social assistance is **18 times higher** than higher income individuals.

Cancer:

- Prevalence: **Higher** for lung, oral (OR 2.41), cervical (RR 2.08).
- Mortality: **Lower 5-year survival** rates for most cancers.
- Screening: Low income women are **less likely to access** mammograms or Paps.

Other chronic conditions:

- Prevalence: **Higher** for hypertension, arthritis, COPD, asthma. higher risk of having multiple chronic conditions.
- Mortality: **Increased** for COPD.

Infants:

- Infant mortality: **60% higher** in lowest income quintile neighbourhoods
- Low birth weight: If all babies in Toronto were born with the low birth weight rate of the highest income quintile there would be **1,300** or **20%** fewer singleton LBW babies born per year.

Highest risk groups:
Women, First Nations, people of colour, LGBT.

Growing up in Poverty:

We must intervene to improve income early.

Growing up in poverty has been associated with increased adult morbidity and mortality resulting from: stomach, liver, and lung cancer; diabetes; cardiovascular disease; stroke; respiratory diseases; nervous system conditions; diseases of the digestive system; alcoholic cirrhosis; unintentional injuries; and homicide.

Some examples of how the evidence might change your practice:

1. If an otherwise healthy 35 year old comes to your office, without risk factors for diabetes other than living in poverty, you consider ordering a screening test for diabetes.
2. If an otherwise low risk patient who lives in poverty presents with chest pain, this elevates your pre-test probability of a cardiac source and helps determine how aggressive you are in ordering investigations

3. INTERVENE

7 simple questions to help patients living in poverty

FOR EVERYBODY:

Have you filled out and mailed in your tax forms?

- Tax returns are essential to access many income security benefits e.g. GST / HST credits, Child Benefits, working income tax benefits, and property tax credits.
- Even people without official residency status can file returns.
- **Drug Coverage:** Extended Health Benefits or Trillium for those without a Ontario Drug Benefits.

For seniors living in poverty:

Do you receive Old Age Security and Guaranteed Income Supplement?

- Most people over age 65 who live in poverty should receive at least **$1400/month** in income through OAS, GIS and grants from filing a tax return.

For families with children:

Do you receive the Child Benefit on the 20th of every month?

- This can get some low income single parents over **$8000 more per year**, and can lead to a number of other income supports.

For people with disabilities:

Do you receive payments for Disability?

- Eight major disability programs: ODSP, CPP Disability, EI, Disability Tax Credit (DTC), Veterans benefits, WSIB, Employers' long term protection, Registered Disability Savings Plan (RDSP).
- The DTC requires a health provider to copmlete the application form. It provides **up to $1100 per year** in tax savings (plus retroactive payments), and is required to receive other benefits including the RDSP.
- RDSP: **Up to 300%** matching funds. Or disability bonds **up to $20 000** for those without resources to save money.

For First Nations:

Are you Status Indian?

- First Nations with the Status designation may qualify for Non-Insured Health Benefits through the federal government. These pay for drugs and other extended health benefits not covered by provincial plans

For social assistance recipients:

Have you applied for extra income supplements?

- Mandatory Special Necessities Benefits (*MDs bill K054 for $25*):
  - Medical supplies and health-related transportation (includes e.g. AA, psychotherapy).
- Limitation to Participation (*MDs bill K053 for $15*): Disability can exclude a recipient from mandatory job search and training programs.
- Special Diet Allowance (*MDs bill K055 for $20*): some health conditions will qualify a recipient for extra income.
- Other benefits available: Employment supports, Drug & Dental, Vision, Hearing, ADP Co-payment, Community Start Up & Maintenance, Women in Transition/Interval Houses, Advanced age allowance, Community Participation ($100 per month extra for volunteering). "Discretionary Benefits".

Applications and benefits available through a patient's OW/ODSP worker

If you might qualify, have you applied for ODSP?

- ODSP application (MDs bill K050 for $100): provide as much information as possible, including about the impact of a person's disability on their lives.
  - Include all collateral, expedite necessary referrals, and write a detailed narrative on the last page. Consider obtaining a detailed functional assessment, and having an allied health provider assist with filling in details.
- If denied, refer to nearest legal clinic – acceptance rates on appeal are very high.

www.cleo.on.ca/english/pub/onpub/PDF/socialAsst/ods-prof.pdf for a good ODSP tip sheet for health professionals.

Remember:
Health providers are not the gatekeepers for income security programs. Our job is to provide complete and detailed information that accurately portrays our patients' health status and disability.

For references, please visit
www.ocfp.on.ca/cme/povertytool

Developed by Dr. Gary Bloch MD CCFP,
with support from:

St. Michael's
Inspired Care. Inspiring Science.

HEALTH PROVIDERS AGAINST POVERTY

St. Michael's Hospital
Family Medicine Associates

Broden Giambrone MHSc,
Research Assistant

For more information and references visit:
www.ocfp.on.ca/cme/povertytool

Norwegian Public Health Act

The new Public Health Act will be introduced in Norway from 1 January 2012. The purpose of this Act is to contribute to societal development that promotes public health and reduces social inequalities in health. Public health work shall promote the population's health, well-being and good social and environmental conditions, and contribute to the prevention of mental and somatic illnesses, disorders or injuries. The Act establishes a new foundation for strengthening systematic public health work in the development of policies and planning for societal development based on regional and local challenges and needs. The Act provides a broad basis for the coordination of public health work horizontally across various sectors and actors and vertically between authorities at local, regional and national level. Only by integrating health and its social determinants as an aspect of all social and welfare development through intersectoral action, can good and equitable public health be achieved.

Multiple stakeholders

The municipalities, county authorities and central government authorities are all important actors in the efforts to promote public health and reduce social inequalities in health. This Act shall ensure that municipalities, county authorities and central government health authorities implement measures and coordinate their activities in the area of public health work. Promotion of participation and collaboration with stakeholders such as voluntary sector is an important aspect of good public health work. Central government health authorities have a duty to support the public health work of the municipalities among others by making available information and data to monitor public health and health determinants at local level. The Act aims to facilitate long-term, systematic public health work.

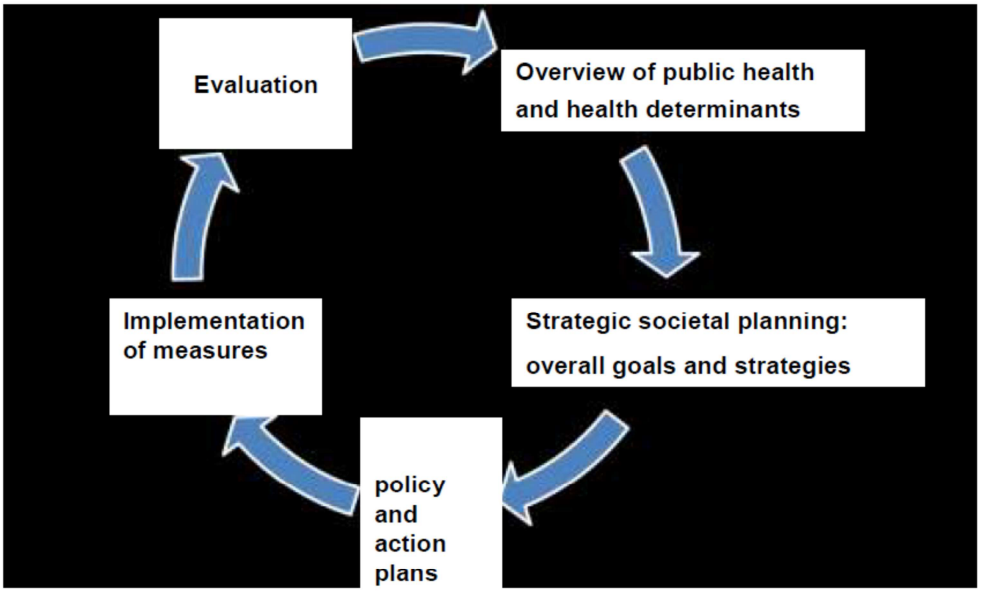
Principles of public health

The Act is based on five fundamental principles that shall underpin policies and action to improve population health. The principles are:

- ***Health equity:*** Health inequities arise from the societal conditions in which people are born, grow, live, work and age – the social determinants of health. Social inequities in health form a pattern of a gradient throughout society. Levelling up the gradient by action on the social determinants of health is a core public health objective. A fair distribution of societal resources is good public health policy.
- ***Health in all policies:*** Equitable health systems are important to public health, but health inequities arise from societal factors beyond health care. Impact on health must be considered when policies and action are developed and implemented in all sectors. Joined up governance and intersectoral action is key to reduce health inequities.
- ***Sustainable development:*** Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Public health work need to be based on a long term perspective.
- ***Precautionary principle:*** If an action or policy has a suspected risk of causing harm to the public or to the environment, the absence of scientific consensus that the action or policy is harmful, cannot justify postponed action to prevent such harm.
- ***Participation:*** Public health work is about transparent, inclusive processes with participation by multiple stakeholders. Promotion of participation of civil society is key to good public health policy development.

Systematic public health work

One of the main features of the Act is that it places responsibility for public health work is as a whole-of-government and a whole-of-municipality responsibility rather than a responsibility for the health sector alone. In public health work the municipalities must involve all sectors for the promotion of public health, not just the health sector.



The Act builds on a broad determinant perspective on public health work. Overview of public health and health determinants constitutes the starting point for evidence based public health work. Based on a local assessment of the public health challenges, public health policy development must be an integrated part of ordinary societal and spatial planning and administration processes in counties and municipalities and in other social development strategies.

Instead of detailed requirements, the Act prescribes procedural requirements that will provide the municipalities and counties with a foundation for systematic and long-term public health work across the sectors, based on the municipalities' own planning and administration systems. The municipality shall implement the measures that are necessary for meeting the municipality's public health challenges. This may, for example, encompass measures relating to childhood environments and living conditions, such as housing, education, employment and income, physical and social environments, physical activity, nutrition, injuries and accidents, tobacco use, alcohol use and use of other psychoactive substances.

Swedish National Institute of **Public Health**

2003 2013

Sweden and the world: 10 years of a health determinants-based national public health policy

– Reflections on national and international public health implications of Sweden's public health policy, 2003–2013

PLACE City Conference Center, Stockholm, Sweden

DATE 13 May, 2013

DAY 1 International Perspective – To what extent have the social determinants of health become anchored in various national and international public health policies? What can we learn from each other?

The conference will continue on May 14 with a national focus and will be held in Swedish.

For more information and registration, please visit **www.fhi.se/swedenandtheworld**

I look forward to welcoming you to Stockholm in May 2013!

Dr. Sarah Wamala,
Director General,
Swedish National Institute of Public Health

In 2013, ten years will have passed since the Swedish government established a national public health policy based on the social determinants of health, embodied by one overarching goal: to create societal conditions that will ensure good health, on equal terms, for the entire population.

Eleven goal areas which covered the most important determinants of Swedish public health were established under this overarching goal, together with a comprehensive set of indicators to follow the health progress of the population.

In an increasingly globalized world however, is one country's public health policy merely a drop in the bucket, or are there ripple effects? This international conference aims to bring together the makers, analysts and researchers of public health policy in various countries to discuss the inspirations, trends and outcomes of the last decade, with Sweden's own work as one example.

- To what extent have the social determinants of health become anchored in various national and international public health policies?
- Do national public health policies influence or inspire similar work in other countries?
- How does a national public health policy influence public health practice at national, local and regional levels?
- How does a national public health policy influence the political agenda regarding public health investments?

Swedish National Institute of **Public Health**