The Relevance of the Social Determinants of Health to Catholic Health Professionals in the next Decade
- A 10 Year Plan to Deliver Health Care Before It is Needed

2010 Catholic Health Australia Conference
Adelaide Convention Centre
25 August 2010

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I acknowledge the Kuarna people, the traditional owners of the land on which we meet, and I pay my respects to their ancestors. I am happy to report that at St Vincent’s Health Australia we commence every board meeting with such an acknowledgment. We are one of the first health providers to finalise a Reconciliation Action Plan approved by Reconciliation Australia. I commend the initiative to others in the Catholic Health network.

I am delighted that we commenced the day with a prayerful reflection on Mary Mackillop and Julian Tenison Woods. I am overjoyed that Mary Mackillop is to be canonised in the near future, and I have every hope of being in Rome for the occasion. She did much to educate and liberate the poor Irish Catholics who migrated here. My own Irish forebears owe much to Mary’s co-founder Julian Tenison Woods who eventually fell out with her, thinking in part that the Jesuits had infected her mind permitting her to loosen up too much on their original shared vision of poverty and obedience for the sisters. It just happened that Woods on one of his scientific expeditions turned up in Maryborough in Queensland where my widowed great great grandmother Annie Brennan had arrived in 1862 with her five children – a courageous move by any reckoning. Family legend has it that Woods got my great grandfather Martin off the grog and back to church. So his next son, my grandfather, was named Frank Tenison Brennan, as am I. My grandfather went on to become Minister for Public Instruction in the Queensland Labor Government before then being appointed to the Supreme Court. Even putting aside the family connection to Tenison Woods, the story of Woods and Mackillop will be of increasing interest to many Australians (especially Catholics) in the wake of Mary’s forthcoming canonisation. One of the good things about a canonisation is that ordinary events and ordinary connections in life take on a graced dimension. Our history becomes holy.

Last week I was in Townsville and on Palm Island, home of the largest Aboriginal community in Australia. The people there have been doing it very tough these last six years as they have dealt with the death in custody of their brother Cameron Doomadgee and the protracted cover-ups and incompetence of the Queensland Police Service. I was first invited to go to Townsville on this visit to speak at the annual dinner of the local law society. One of the Aboriginal leaders getting wind of this, phoned and asked if I could speak at the annual NAIDOC ball that same night. Then the church leaders got word and organised meetings on Townsville and Palm Island. The bishop attended the Townsville meeting but the Aboriginal leader Lex Wotton
was not permitted to attend, that being a condition of his parole. While no policeman has been punished or disciplined for the death of Mr Doomadgee who died of a ruptured liver at police hands, Wotton served two years in jail for rioting when the community received word of Doomadgee’s death. When I arrived on Palm Island this time, I met the new parish priest, Fr Daniel. He has arrived recently in Australia from Ghana. He drove me around the island and we spoke about his new ministry. One of the Irish sisters on the island wrote to me in the last couple of days, saying: “Many thanks for your very welcome visit to Palm Island. The numbers were not great but I believe your words brought healing to some of the deeply wounded in our community. The experience for Fr. Daniel was pretty special and drew tears to his eyes as he touched into the pain of our aboriginal brothers and sisters. He said he felt their anguish and indeed recognised it to be somewhat similar to the plight of his own people during the times of the slave trade in West Africa.” There is no substitute for being there and feeling the pain of people who are suffering injustice.

As we are waiting for the result of last Saturday’s federal election to be revealed, it is fashionable to tell stories about the three independents, including Bob Katter under his large hat. I recall a meeting on Palm Island in 1985. Bob was Sir Joh Bjelke-Petersen’s minister for Aboriginal Affairs. Clyde Holding was Bob Hawke’s Commonwealth Minister for Aboriginal Affairs. Clyde and Bob were promising national land rights and self-determination for these Aboriginal communities – the equivalent of national health reform! The leaders of all the Queensland Aboriginal reserve communities were in attendance. I was there as their legal adviser. Holding was accompanied by a very intelligent adviser from Canberra. Katter as ever was running late. Holding had the floor to himself. He was outlining Canberra’s grand vision. Then an hour late, Katter rushed in with the big hat and he went around the room greeting every Aboriginal leader by name and asking a question or two about the most local of issues from each of their communities. The Commonwealth adviser was devastated. By the time Katter had got half way around the room, Holding looked plaintive, wondering when that next plane to Canberra might be leaving. Grand plans go nowhere unless we are grounded, connected, and in relationship with those we are professing to serve.

It was very heartening for us all to hear from Archbishop Philip Wilson yesterday. The president of the Australian Catholic Bishops Conference, he reminded us of the troubles encountered by St Bart’s Hospital in London, having survived 900 years under the patronage of St Bartholomew – the saint whose feast we celebrated yesterday. Speaking of governance, he did not want to raise any issue of “an ecclesial deficit”, he simply wanted to urge us to know and pray the scriptures – at home, at work, and around the board table. The Old Testament challenge for us is always to ask, how are we serving the poor, the widow and the orphan? How are we providing for them? How are we including them?

No matter what our charism or our market, we know that we cannot provide first rate 21st century health care to all the world’s poor, widows and orphans. Our New Testament perspective is given us in the well known story of the last judgment in Matthew’s Gospel 25:34-46:

Then the King will say to those on his right, ’Come, you who are blessed by my Father; take your
inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.’

Then the righteous will answer him, 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?' The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.'

Then he will say to those on his left, 'Depart from me, you who are cursed, into the eternal fire prepared for the devil and his angels. For I was hungry and you gave me nothing to eat, I was thirsty and you gave me nothing to drink, I was a stranger and you did not invite me in, I needed clothes and you did not clothe me, I was sick and in prison and you did not look after me.'

They also will answer, 'Lord, when did we see you hungry or thirsty or a stranger or needing clothes or sick or in prison, and did not help you?' He will reply, 'I tell you the truth, whatever you did not do for one of the least of these, you did not do for me.' Then they will go away to eternal punishment, but the righteous to eternal life.

No matter how righteous we might be, each of us knows that for every hungry person to whom we give a meal, there will be hundreds of others we will never feed. For every thirsty person to whom we give a drink, there will be thousands of others we will never reach. Just contemplating the devastation of Pakistan with the floods at this time, we know that for every naked person to whom we offer clothes, there will be millions more who remain homeless and unclothed. There is just no way that the Australian Catholic health providers could find the resources to provide appropriate health care for all Australians, let alone all those living in our region. We need to be sure that no group is systematically excluded from our consideration and care. We can only treat some, but we do not exclude whole groups from our embrace on any grounds including capacity to pay. Our Church tradition speaks of a preferential option for the poor which finds resonance in the contemporary notion of progressive universalism. As Sir Michael Marmot puts it: “Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.” In the decade ahead, we need to acknowledge that our health services in the Catholic tradition are not services offered, administered and supervised only by Catholics. They are services staffed by persons of all faiths and none who are committed to our vision of health care and who participate fully in our ministry of healthcare in the Catholic tradition. We are grateful to these persons whatever their faith, and hopefully they are grateful for the Catholic tradition because of the values, ethos, and priorities it impels in those committed to comprehensive health care.

In the decade ahead, we need to be better educated about the social determinants of health if we are to live this mission to the full. The World Health Organisation (WHO) established the Commission on Social Determinants of Health (CSDH) in 2005. That commission produced its report in 2008 entitled Closing the gap in a generation: Health equity through action on the social determinants of health. The report contained three overarching recommendations:

1. Improve daily living conditions
2. Tackle the inequitable distribution of power, money, and resources
3. Measure and understand the problem and assess the impact of action

Professor Fran Baum from Flinders University was a member of that WHO Commission. She heads the Southgate Institute for Health, Society and Equity (see http://www.flinders.edu.au/medicine/sites/southgate/southgate_home.cfm). Australia is blessed to have such an authority on social determinants. We should make something of this opportunity.

It is self evident that economics, social policy and politics impact on the social determinants of health. It is self evident that the person from a well resourced functional family is likely to have better health outcomes than the person from the poor dysfunctional family. These social determinants include financial status, employment and work environment, education, and housing. It is also self-evident that there is some relationship between these determinants and lifestyle choices and characteristics including tobacco use, alcohol consumption, obesity, high blood pressure and cholesterol. If our concern is to maximise good health outcomes for an entire society and not just those who occupy our acute beds from time to time, it is not enough just to consider the quality of our services to those once they are in the beds. The UK National Audit Office puts it this way:

![Diagram of the causes of health inequalities](image)

In the UK, they have spent a decade trying to address these social determinants of health. In July 2010, the National Audit Office produced its Report on the Department of Health: Tackling inequalities in life expectancy in areas with the worst health and deprivation. Progress is excruciatingly slow.

The press release accompanying the release of the report notes:

The Department of Health has made a serious attempt to tackle health inequalities across England. But, according to a National Audit Office report published today, having set a target in 2000 to reduce health inequalities, it took time to embed the issue in the policy and planning framework of the NHS and to develop an evidence base of the most cost-effective interventions.

..........The NAO report found that, although life expectancy overall has increased, the gap in life expectancy between the national average and the Government’s dedicated “spearhead” areas has continued to widen. The Department will not meet its target to reduce the health inequalities gap by 10 per cent by 2010, as measured by life expectancy at birth, if current trends continue.
Let me say a word about six major challenges for Catholic Health in Australia in the next 10 years:

1. **The Hurricane of Change – COAG reforms**
We are all going to have to adapt to the changes being imposed by governments and the market. Boards and senior management are not going to emerge from this quagmire anytime soon.

2. **Rationalisation to between 10 and 20 Catholic organizations under a federal model?? InFORMATION – growing and sustaining our ministries**
There will be much time and energy expended on deciding whether Catholic health providers should opt for minimal convergence, maximum convergence, or a federated model resulting in “10 to 20 Catholic organizations under a federated model, which would enable each organization to retain significant diversity and separate focus, with sustainability in size and scale”.

3. **Breaking down the silos between health, welfare and education**
One of the great strengths of the Catholic Church in Australia is that we have a strong presence in health, welfare and education. But we do tend to stick to our silos when it comes to co-operation and ways of thinking. If we are to educate people for better health outcomes, we need greater co-operation between those in the health and education sectors. If we are to better serve the person with health and welfare needs, we need greater co-operation between those organisations under the umbrella of Catholic Health Australia and those under the umbrellas of Catholic Social Services Australia and the Society of St Vincent de Paul. I would hope that my joint appointment as advocate in residence for all three could assist in this task of silo dismantling.

4. **Ecclesial Deficit**
With the establishment of public juridic persons (PJPs) and with the ageing and diminishment in numbers of religious sisters (now with a median age of 74 years), there have been some murmurings about an ecclesial deficit in the oversight of Catholic health facilities. It was very heartening to hear Archbishop Wilson when addressing the issue of governance placing such an emphasis on knowing and praying the scriptures. I took this as an indication from the President of the Bishops Conference that the bishops do have confidence in us, the persons at our board tables and the persons directing the day-to-day activities of our health institutions. We are just as equal to the task of incarnating gospel values and acting according to the Catholic tradition as were the sisters, doctors and nurses in a bygone era when, let’s face it, the bishops were not much in evidence around the wards, in the consultation rooms, or in the board rooms. Back in March 2010, Archbishop Coleridge when speaking of the negotiations over the Calvary Public Hospital in Canberra, said, “The task now is for all to act together to ensure the best possible health care for the people of the ACT community at a time when health care is becoming more complex and costly, and for the Catholic parties to work together ‘ecclesially’.”
5. **Option for the poor**

My fear, and my challenge to you, is that in times past the Church was the provider of services to the poorest and most marginalised. Now, even we presume that the primary provider is the State. The State has replaced the Church as the primary provider in facing the challenge put before us in Matthew 25: “whatever you did for the least of these, you did for me”. Knowing about the social determinants of health, we need to see how we as Church can contribute to improving people’s living circumstances. We also need to see how we can contribute to better lifestyle choices by people. Then, and only then, do we need to consider access to appropriate health care – how we could improve people’s access and the quality of care.

6. **Being Effective Advocates for Reform**

There are bioethical questions on which we Catholics are likely to have a particular “take” and we have not been afraid of advocating such positions. We are also adept at advocating the cause of our institutions with government and the insurers. But we could be more eloquent advocates for justice in the area of health reform.

Here is one example. The Rudd Government set up the Disability Investment Group (DIG), to consider new approaches to disability. They recommended that the Australian Government, in consultation with States and Territories, immediately commission a comprehensive feasibility study into a National Disability Insurance Scheme. That group included very competent individuals including Bill Moss with a serious disability and Bruce Bonyhady with children affected by a serious disability. Last Saturday, there was a splendid interview with Bill Moss who made his fortune at Macquarie Bank. The *Sydney Morning Herald* article was entitled “Fabulously rich and still begging”. Moss recalled the time at the Bank when he asked an underling, “Whatever happened to that person I referred through?” The answer: “Oh, we couldn’t employ them because they had a disability.” Where will we be situated in the debate about an NDIS when the Productivity Commission reports next June?

In the light of these six challenges, let’s now consider the facts revealed on the following PowerPoint and ask how we want to be situated in a decade from now, true to our mission.

Last year I was privileged to chair the National Human Rights Consultation Committee established by the Rudd Government. Our task was to assess community views about the protection of human rights in Australia. Most Australians think this is a great place to live. Most of us think our human rights are pretty well protected.
We were surprised to learn that health concerns are top of the pops when it comes to Australians prioritising the relative importance of social issues.

Even though this is one of the best countries in the world in which to live, we know that there are some groups in the community who still get a bad deal. They do it tough. The social researchers conducted a random telephone poll of 1200 Australians. They asked: “I’m going to read out some groups now. For each, do you feel their human rights need to be given more, less or the same amount of protection as they are currently getting in Australia?” Here are the responses:
More than 70% of us think that though this is the best of all countries to live in, people with mental illness, the elderly and people with disabilities still need better protection of their basic human rights. More than half of us are convinced that people in remote areas (especially Aborigines) are doing it too tough. Perhaps there is some metanarrative of justice in the three regional independents now having the balance of power!

In the UK, Sir Michael Marmot this year completed his report on social determinants of health entitled *Fair Society, Healthy Lives*. He looked at life expectancy and disability-free life expectancy (DFLE) at birth of persons according to their neighbourhood income levels:
There is the double whammy. If you live in a poor neighbourhood, you will not only live less. You will spend more years living with a serious disability:

**Figure 2.8 Number of years from birth spent with disability, persons by neighbourhood income level, England, 2001**

Males in the most deprived neighbourhoods will suffer the ills effects of circulatory disease in excessive numbers:
There are also major deviations in the incidence of cancer death rates at ages under 75 years:

For the last two years here in Australia, the Prime Minister has provided the parliament with a *Closing the Gap* report on the state of Aboriginal health. Aboriginal life expectancy is still a national disgrace.
It is fashionable in Australia to speculate that the grog is a major cause of adverse Aboriginal health outcomes. It is a contributing cause, but by no means the most significant one:

Just look at the gap in child mortality in this first world country, Australia, and ask what we Catholic health care providers are doing about it:
This year the National Preventative Health Taskforce has also issued a report on lifestyle issues affecting the nation’s health. *Taking Preventative Action – A Response to Australia: the Healthiest Country by 2020* lists the issues of concern:
Here is a graph which should cause considerable upset to all health providers in contemporary Australia:
What are we doing to our children? What are we allowing them to do to themselves? When addressing lifestyle issues like obesity and smoking, it is too simplistic to launch campaigns saying “Quit”. If a child is in a loving, supportive environment where most other persons in the environment are living healthy lives, it may be possible to be prescriptive. But what are we to do when the child’s peers and role models are also engaged in the same behaviour?

Next month, CHA will be releasing a report commissioned from NATSEM entitled *Health Lies in Wealth: Health Inequalities in Australians of Working Age*. This will be a very useful resource for us as we provide some resources for our health workers becoming conversant with social determinants of health. Here is NATSEM’s finding
about tobacco smoking status (per cent of individuals) by age, sex and household joblessness:

The good news is that smoking rates have reduced in Australia:

Increasing the excise has probably helped in reducing the incidence of smoking:
NATSEM has tracked the per cent of persons reporting good health, by sex, age and housing:

NATSEM has also tracked the per cent of persons reporting good health, by sex, age and education:
And the *Closing the Gap* report highlights the gulf in educational attainment still existing for indigenous Australians:

**Figure 15:** In 2006, the gap in the Year 12 or equivalent attainment rate between indigenous and non-indigenous 20–24 year olds was 36.4 per cent.¹⁸

Source: Council of Australian Governments Reform Council National Education Agreement: Baseline performance report for 2008

There are many gaps that still need to be closed if we are to have better health outcomes.
I have provided minimal comment on these graphs and statistics. My purpose is to prompt you to reflect on the six major challenges I have put before you against the backdrop of these materials which provide the context for the health provider wanting to achieve progressive universalism.

As the representatives of Catholic Health surely our boast must be: There is no class of persons we turn away; there is no class of persons with whom we fail to engage; there is no class of persons to whom we do not have outreach. We do maintain a practical commitment to the poor, the widow and the orphan. In contemporary Australia that must include a commitment to:

- Those with mental illness
- The aged
- Those with disabilities
- Those in rural areas (especially those on remote Aboriginal communities)

The heartening thing I have found in my visits to your workplaces thus far is that in each of our institutions there is someone who has this commitment, this passion. Our first task must be to give support and encouragement to these individuals. We also need to provide them with networks. It would be invidious for me to mention anyone from the St Vincent’s Health Australia so let me single out those at St John of God who have been spearheading their Social Outreach and Advocacy Program and Coralie Kingston responsible for Mission Integration at Mercy Health and Aged Care Central Queensland

In this task, we are not on about guilt, paralysis, and stretching ourselves to breaking point. Rather we are on about liberation, opportunity, connectedness and balance.

We want our health care institutions to be privileged places to be and work where we have the Christian balance right. We are committed to excellent, universal health care of persons and the community where no group is excluded for want of funds, education, employment or housing. We work co-operatively with others to set the right conditions for good health and good health care for all.

We need the Holding plan and the Katter contact. Like Fr Daniel from Ghana we need to touch the pain of the people of Palm Island. Like my great grandfather
Martin, we need to encounter the enigmatic Julian Tenison Woods and come back to the wellsprings which can motivate us to reach out to all who need our healing touch, assured that the King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.' On 17 October when Mary Mackillop is canonised in the Vatican piazza in front of St Peters, let’s remember that the ordinary events and ordinary connections of our lives can take on a graced dimension. Our history has become holy. We are called to be reverent healers. That’s what we do well, because that is us at our best as Catholic Health Australia.