Standing Committee on Social Issues

Inquiry into Prevalence, Causes and Impacts of Loneliness in New South Wales

Public Hearing - 15 November 2024

BCEC responses to questions on notice

Question 1:

The Chair: Is there any other work, research or estimates out there which perhaps use a broader idea of cost? Health costs are helpful because that's very tangible and governments understand health costs, but productivity costs? We had someone earlier today say it was also the cost of people not engaging in education et cetera, which I guess less tangible. Do you know of any studies anywhere that have that broader cost lens?

BCEC response:

There is a lack of peer-reviewed studies in Australia and other countries estimating the economic costs of loneliness beyond healthcare-related categories (Kung et al., 2021).

Mihalopoulos et al. (2020) reviewed 12 studies on the economic costs of loneliness and social isolation conducted in countries such as Portugal, the UK, and the USA. Four of these studies estimated the costs associated with loneliness, while the others evaluated the cost-effectiveness of seven loneliness interventions. However, the review highlighted that these studies primarily focused on healthcare-related costs, such as inpatient and outpatient expenses and the costs of residential care.

Some insights can be drawn from a limited number of reports. For example, the *2020 Loneliness Monetisation Report*[1] in the UK estimated the economic impacts of loneliness on subjective wellbeing, health, and productivity. The report found that severe loneliness leads to a monetary loss of approximately £330 per person per year due to its negative impact on productivity and £9,537 per person per year due to its effects on wellbeing.

Another report by Michaelson et al. (2017) estimated that loneliness costs employers in the UK £2.5 billion annually. The primary direct costs include £20 million due to increased sickness absence, £220 million from employees' caregiving responsibilities for individuals whose health issues are linked to loneliness, £665 million in lost productivity, and £1.62 billion from higher voluntary staff turnover caused by reduced job satisfaction.

Question 2:

The Chair: Could I maybe replicate my last question and say if you have any studies about social prescribing, that would also be very useful.

BCEC response:

Included below is the original section from our 2021 report discussing UK and international developments in social prescribing and their implications for reducing health system costs and introducing preventative health strategies in Australia.

We have briefly reviewed more recent evidence since out 2021 report across the relevant international journals and included an updated list of key references for the Committee to consider.

[1] Available from: https://www.gov.uk/government/publications/loneliness-monetisation-report

The new evidence adds to our original work and reinforces our original recommendations and conclusions. We have included some more recent studies from Australia that will be of direct interest to the Committee.

Question 3:

The Hon. SCOTT BARRETT: Maybe again on notice, I noticed that maps that BCEC has in its submission. This is obviously a national study. Is there a chance we could get a more focused NSW map for that?

BCEC response:

Please see the **attached** pdf file.

Health, loneliness and social prescribing (2021)

Over the last decade health and policy experts in the UK have been trialling approaches to tackling the social determinants of health, including loneliness and social isolation as part of a model described as 'social prescribing' (NHS 2021). They did so in recognition that around one in five patients came to GPs for social reasons (Torjesen 2016) and that 80-90% of health outcomes were linked to health-related behaviours, socioeconomic and environmental factors (Janti et.al. 2020). The Kings Fund UK (one of the major funders of these trials) defined social prescribing as "a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services," (Kings Fund 2017).

The key lynch-pin in the efficacy of the UK social prescribing model is the role of link workers, who "…give people time and focus on what matters to the person as identified through shared decision making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support." (NHS 2021a) The link worker engages with the GP and the patient to determine their aspirations and interests alongside their health, support and engagement needs, then leverages their knowledge and relationships with local community organisations to develop a supported placement into voluntary work or participation. Similar models have also been trialled in Canada and New Zealand.

In January 2019 the NHS UK announced a major expansion of social prescribing as part of its' comprehensive model of patient care. Social prescribing is now being rolled out at scale across the whole of the UK primary health system. The UK alongside Japan also has a Minister for Loneliness.

In November 2019 the Royal Australian College of General Practitioners and the Consumer Health Forum of Australia held a roundtable to discuss the application of social prescribing models to a range of health challenges in Australia. They argue that current systems are inadequate to meet the increasingly complex health and social needs of patients, and an effective approach requires that we break down the siloes between health, community and volunteer-run services and activities. (RACGP 2019).

The RACGP roundtable recommended that we needed to start planning to incorporate social prescribing into our primary health system in Australia – enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services (RACGP 2019). Over time this could dramatically reduce the cost of tertiary health services of poor mental health through chronic health problems like obesity and heart disease. The community campaign group *Ending Loneliness Together* are calling for the same thing.

If we are to achieve better health and social outcomes, it is important that we make the connections to the social determinants of health. Our findings in this report show that poverty is a very strong predictor

of loneliness, and that disadvantaged groups within our community including people with a disability and Aboriginal communities have lower social capital and connectedness and are at much greater risk of loneliness and poor health.

When social prescribing is done well it enables us to get closer to the root cause of the problem in a way that medicine alone cannot, improving impact and reducing demand on health services. To be effective it is critical that the approach is person-centred and focused on what really matters to the individual – hence the activity should be meaningful, sustainable and connecting – building on their interests and strengths to engage, enable and empower.

An effective social proscribing approach shifts the focus from illness to wellness, improving prevention and management of physical and mental illness. It increases individual enablement and self-management, leading to a more comprehensive and holistic model of service delivery. It reduces feelings of helplessness in both patients and providers to reduce social isolation and loneliness, creating stronger more connected communities.

So, what does this mean for policy makers and system managers? An effective service solution requires understanding and alignment on both sides of the equation. Concern has been raised by the national rollout of social prescribing through the NHS in the UK because the focus has been predominantly on the health system side of the equation, with insufficient consideration given to the impacts on local voluntary organisations, their capability and resources to manage an influx of volunteers who may be expecting to be service recipients rather than providers and may require additional support for other complex needs.

Incorporating social prescribing into our primary health system and Medicare requires a level of understanding and a significant shift in practice for local GPs, both in how they assess need and how they prescribe particular activities. It is unrealistic to expect GPs to have sufficient understanding of community development and social work to be able to connect the right patients to the right activities, so a degree of specialised referral is required. In the UK they are investing in link worker roles that build on existing skills and experience, while developing appropriate training and qualifications. In Australia, Primary Health Networks and Aboriginal Community Controlled Health Services are well placed to make this happen.

Meanwhile governments need to be working with local councils and peak bodies, community resource and neighbourhood centres (and specialist community development networks like Befriend[2]) to identify appropriate community services or groups, build their capability to manage and support volunteers, and put in place the systems and resources to scale up to effectively enable referrals. Existing initiatives like WA Connect[3] can be scaled up to help develop community directories that provide the right information to support informed choices and referrals.

Governments also need to work with researchers to update existing policies and programs and put in place evaluation measures and frameworks that track meaningful outcomes and demonstrate the return on investment of preventive health interventions.

The place to start is for governments to pool funding to enable social prescribing pilots across a range of different communities, activities and cohorts – to test the model and build the evidence base. It doesn't need to be top down or expensive. Ultimately, we all want to find meaning and purpose in our lives – to be connected and feel like we are part of a community and making a difference. Getting the information

[2] Befriend Inc. https://befriend.org.au/
[3] WA Connect – Community Services Directory https://waconnect.org.au

out to citizens and putting in place systems and supports that make it easy for them to choose, engage and connect may be enough. Build it and they will come.

Recommendations

1. Develop social prescribing models and mechanisms to enable health professionals to connect those in need with relevant local voluntary organisations and supports
2. Build the expertise in GPs and health workers, volunteer managers and link workers to make the connections for meaningful voluntary participation in local communities
3. Target outreach and support to those most at risk of loneliness, including disadvantaged groups and people facing life transitions. Provide the support they need to be able to participate (like transport and universal access).
4. Push our governments to address the social determinants of health – tackle poverty, build secure and affordable housing, and create jobs that are meaningful, secure and rewarding.
5. Look around to see what we can do where we live to create connection, working with networks like Befriend to support local leaders and groups to codesign meaningful activities that change lives and build communities.

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International definition of social prescribing

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UK Health System links:

- https://www.england.nhs.uk/personalisedcare/social-prescribing/
- https://londonplus.org/social-prescribing-resources/

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/position-statement-ps01-21---social-prescribing---2021.pdf?sfvrsn=2b240ce4_2

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Further information

The Bankwest Curtin Economics Centre (BCEC) is an independent economic and social research organisation located within the Curtin Business School at Curtin University. The Centre was established in 2012 through the generous support of Bankwest, a division of Commonwealth Bank of Australia.

Links to BCEC research are available through our website at: https://www.bcec.edu.au