Chapter 5
Research and Reporting

5.1 One of the three overarching recommendations of the WHO Report was to 'Measure and Understand the Problem and Assess the Impact of Action'. This included specific recommendations on ways to improve the generation of new evidence concerning the social determinants of health. Health problems caused by social determinants are only recognised through the collection and analysis of data. The report emphasises the value of good data in tackling these problems:

> Good evidence on levels of health and its distribution, and on the social determinants of health, is essential for understanding the scale of the problem, assessing the effects of actions, and monitoring progress.[1]

5.2 The Department reported to the committee that problems do not lie with the quantity of data that is collected, but rather with the capacity to analyse the data:

> There is, and I think our submission reflects this, a lot of data collected in Australia and there is a lot of different kinds of data collected. There is administrative data, there are surveys, there are longitudinal surveys and there is work that has been going on with quite a bit of intensity in recent years about linking administrative records to get longer term pictures…I wonder sometimes, when people raise this question, whether they are actually asking for more analysis rather than more data…It is like everything: there has got to be some trade-off about how much data you collect.[2]

Current data gathering capacity

5.3 Much of the health data captured for the government is done through the AIHW. According to their submission the AIHW has recently been involved in a number of projects that aim to improve the knowledge base in this area. They provided examples of reports produced on:

> [T]he social distribution of health risk and health outcomes; the health of males in five key population groups; and lung cancer by socioeconomic status (including risk factors, incidence and mortality rates). In addition to this work, AIHW has created an on-line Indigenous Observatory, reports against 68 indicators as part of monitoring the Aboriginal and Torres Strait Islander health performance framework, has been involved in establishing

---

1 CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization. Executive Summary, Part 3, p. 20.

2 Ms Goodspeed, Assistant Secretary, Department of Health and Ageing, *Committee Hansard,* 23 November 2012, p. 36.

> the Closing the Gap Clearinghouse and has been accredited as an integration authority for undertaking data linkage.[3]

5.4 In the most recent publication of the bi-annual report, *Australia's Health* there is a section included on the social determinants of health. The report recognises the difficulties in measuring the effects of the various determinants and the section briefly looks at individual as distinct from community risk factors. It also differentiates between 'upstream' and 'downstream' determinants. Upstream determinants are described as education, employment, income and family structures, and suggests that these are 'more directly influenced by the broad features of society; that is, our culture, resources and policies.'[4] According to Community Indicators Victoria, 'downstream determinants are where we already know we have the problem', and 'tend to be more illness or medically focused.'[5] AIHW use the examples of smoking prevention or efforts to tackle teenage drinking as measures to address downstream determinants. [6]

5.5 While the *Australia's Health* report does not provide explicit data on the impact on health of social determinants it does refer to studies on how health risk factors, including social determinants contribute to the burden of disease and ill health:

> The effect of risk factors on health depends not only on their prevalence in the population but also on the relative amount they contribute to the level of ill health. Studies that quantify this burden use a measure of disability-adjusted life years (DALYs) to describe the relative contribution of specific illnesses and risk factors to the overall burden of ill health.
>
> Australia's most recent national study of the burden of illness and injury used data from 2003 and summarised the contribution of 14 selected risk factors to the national burden for that year. The joint contribution of those determinants to the total burden was 32%. That is, of all the ill health, disability and premature death that occurred in Australia in 2003, almost one-third was attributed to the presence of the health risk factors studied.[7]

5.6 The Department outlined in their submission the current data gathering activities undertaken across government that support the development of evidence base of factors that impact on health outcomes. These include:

- 2011-13 Australian Health Survey (ABS);
- Past National Health Surveys, conducted 3 yearly since 2001 (ABS);

---

3 Australian Institute of Health and Welfare, *Submission 36*, p. 3.

4 Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW. p. 11.

5 Dr Davern, Research Fellow, Community Indicators Victoria, *Committee Hansard*, 4 December 2012, pp 14–15

6 Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW. p. 11.

7 Australian Institute of Health and Welfare 2012. Australia's health 2012. Australia's health series no.13. Cat. no. AUS 156. Canberra: AIHW. p. 15.

- Survey of Disability, Ageing and Carers (ABS);
- Periodic Mental Health Surveys (ABS);
- Periodic General Social Surveys (ABS)
- Census of Population and Housing (ABS);
- Longitudinal Study of Women's Health (DoHA);
- Longitudinal Study of Men's Health – Ten to Men (DoHA);
- Household Income and Labour Dynamics in Australia Survey (FaHCSIA);
- Longitudinal Study of Australian Children (FaHCSIA);
- Longitudinal Study of Indigenous Children (FaHCSIA);
- Longitudinal Study of Australia's Youth (DEEWR); and
- Australian Early Development Index (DEEWR).[8]

5.7 This data is then utilised in the formation of a number of regular reports:

- Measure of Australia's Progress (ABS – last published Oct 2012);
- How Australia's Faring (Social Inclusion Board – last published Sep 2012);
- Australia's Health (AIHW last published in June 2012);
- Social Health Atlases (Public Health Development Unit – available online);
- Australian Early Development Index (DEEWR – last published 2011); and
- State of Preventive Health report (ANPHA – from 2013). [9]

5.8 In all of the recent reforms that were provided by the Department as examples of measures that focus on the social determinants of health, the federal government, in conjunction with the States and Territories through COAG, has identified improved data collection and analysis as key to advancement on tackling adverse health outcomes. Recent reforms in this area include:

- Closing the Gap in Indigenous Health Outcomes;
- Early Childhood Development;
- National Partnership Agreement on Preventive Health;
- Housing and Homelessness;
- National Mental Health Reform;
- Urban Planning; and
- Gender Equity.[10]

5.9 The COAG National Early Childhood Development Strategy - Investing in the Early Years (endorsed in 2009) for example has 'building a better information and a solid evidence base' as one of its six priority areas.[11]

8 Department of Health and Ageing, *Submission 60*, p. 29.

9 Department of Health and Ageing, *Submission 60*, p. 30.

10 Department of Health and Ageing, *Submission 60*, p. 18.

11 Department of Health and Ageing, *Submission 60*, pp. 20-21.

5.10 Medicare Locals are also highlighted as a key service delivery mechanism for implementing action on the social determinants of health. The department submitted information on how data gathering and analysis conducted by the National Health Performance Authority will affect the operation of Medicare Locals:

> The National Health Performance Authority has been tasked with regular reporting on the performance of every Medicare Local areas against a range of agreed indicators. This will provide a means to examine where Medicare Locals are seeing improvements in health outcomes, and give exposure to approaches that are effective using performance indicators defined in the Performance and Accountability Framework (PAF). Medicare Locals are then able to review their results and adjust services in response to changes in needs for their own community.[12]

Gaps in data

5.11 Despite strengths in some areas, the committee received evidence that data blind spots remain that will need to be filled in order to measure and analyse the social determinants of health. FARE noted that there is no national repository of alcohol data, and that the information that is available is often difficult to locate, access and utilise. Furthermore, there is no nationally agreed measure for collecting such data making comparisons difficult.[13]

5.12 The Department also noted that research around the social determinants of health is extremely complex, especially in relation to causal relationships:

> It is so complex that it is very hard to get a comprehensive understanding, through survey data, through the combination of all data, because you will miss certain elements of it. That is the difficulty that we are playing with here: it is an incredibly complex situation.[14]

5.13 The Public Health Association of Australia submitted that there was a need for public health research in general, but as a priority the NHMRC should be directed to fund with specific research into the following areas:

- Understanding social determinants of physical and mental health in Australia;
- Evaluation of public health interventions;
- Aboriginal and Torres Strait Islander health research;
- Health and social policy research, to understand what kinds of policy are best placed to support gains in population health and well-being, and improve health equity;
- Health services research, including in primary health care;
- Research on translation of public health evidence into effective public policy;

---

12 Department of Health and Ageing , *Submission 60,* p. 27.

13 Foundation for Alcohol Research and Education, *Submission 55*, p. 14.

14 Mr Smyth, First Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 23 November 2012, pp. 37–8.

- Understanding, managing and preventing the adverse health effects of climate change; and
- Examining the impact of trade and macroeconomic policy on health and health inequities.

5.14 The Australian Healthcare Reform Alliance was of the view that while there was data available it was not being effectively utilised. They suggested that a national set of indicators on social determinants be created:

> AHCRA supports the development of an agreed set of national indicators on social determinants (such as employment, access to health care and education etc.) and that these are used systematically to assess our progress in these areas. These indicators could then be used to broaden the scope of national agencies, programs and services to ensure they included action on social determinants.[15]

5.15 In their submission Catholic Health Australia proposed that the Productivity Commission should have the primary coordination role in gathering data required to build the evidence base to support policy to address the social determinants of health. This would be achieved through formation of a taskforce modelled on the 'Red Tape Taskforce' that was established in 2006 and provided the foundation for the annual report, *Reducing the Regulatory Burden on Business.*[16]

5.16 The committee was made aware of ongoing discussions concerning the research needs around the social determinants of health. The committee heard from the ANPHA that the Academy of Social Sciences of Australia and the Public Health Association of Australia held a workshop at NHMRC's Canberra Offices on 25 September to discuss important questions around social determinants of health and health equity and to identify priority areas for research.[17]

5.17 The draft recommendations that came out of the roundtable discussion at the workshop were that the NHMRC develop a social determinants of health research funding stream that is open to applications concerning the following:

- Impact of macro-economic environments on health;
- Barriers and opportunities for policy recognition and action on SDH in non-health government agencies;
- The relationship between economic growth and population health outcomes;
- The social determinants of mental health, and of substance abuse;
- The social determinants of Aboriginal health including racism, the impact of colonisation;
- The social determinants of health outcomes at different points in the life course including childhood, working life, parenting and ageing;

---

15 Australian Healthcare Reform Alliance, *Submission 30*, p. 7.

16 Catholic Health Australia, *Submission 19*, p. 39.

17 National Health and Medical Research Council, Research Tracker, 5 October 2012, available at: http://www.nhmrc.gov.au/media/newsletters/research-tracker/2012/research-tracker-5-october-2012, accessed on 17 January 2013.

- Development and application of health equity impact assessments methodologies;
- Assessment of interventions which address the social determinants of health and health equity;
- More social scientists and social determinants researchers should be included as experts on NHMRC panels/review committees and an expert SDH panel should be appointed;
- NHMRC should encourage greater methodological diversity in grant applications and avoid privileging one research approach over another, instead ensuring panels consider the what methodologies are both feasible and relevant in different settings; and
- NHMRC should conduct a detailed analysis of what counts as 'public health research' including the extent of research that could be described as SDH research. This analysis could be used as a baseline to measure NHMRC's success in increasing the amount of SDH research.[18]

Preventative health research

5.18 It was put to the committee that the current focus and funding of healthcare in Australia is weighted severely in favour of treating illnesses after they appear, rather than taking preventative measures. It was observed by St Vincent's Health Australia that:

> In fact, we only get funded when people come through our front door, when we are treating people. We have got the incentives wrong within our system. What we should be doing is working out how we can prevent people coming into that emergency department in the first place.[19]

5.19 This perception of treatment rather than prevention being given priority is also prevalent at the research level. It was noted by representatives from the South Australian Government that this 'there is very little money spent on public health research and preventative health research compared to biomedical research.'[20] Professor Baum, Professor of Public Health at Flinders University, also stated that 'overwhelmingly, NHMRC's budget goes on issues which are about treating people once they get sick. Hardly any of their budget is spent on how we create healthy societies.'[21]

5.20 The Public Health Association of Australia concurred in their evidence to the committee. Professor Moore also highlighted the relative funding for public health research in comparison to medical research:

---

18 Academy of Social Sciences in Australia, *Report on Social Determinants of Health Research Roundtable – Sept 2012*, available at: http://www.assa.edu.au/, accessed 17 January 2013.

19 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 2.

20 Dr Buckett, Director of Public Health, SA Health, *Committee Hansard*, 4 December 2012, p. 22.

21 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, p. 18.

> Research and data are important. Although public health has been generally looked at, it is quite clear … that the poor cousin in research has been areas of public health, such as funding of research by governments.[22]

5.21 Professor Moore expanded on what research should be done, and how it should be utilised most effectively:

> The research should not only look at possible public health interventions but also evaluate what we do. I think that quite often our public health interventions appear to work. We need to look at campaigns—take the Measure Up campaign at the moment—and the sorts of research that needs to go into them. We need to ask whether the outcomes are due to the campaign on its own or whether they are due to the campaign combined with a run of other things that improve public health. Certainly that is the general understanding. We need health policy research to understand what are the best policies and the best practice, how to put policy into practice and how to translate public health evidence into effective policy. These are all areas of research that we believe need to be done. We probably also need to put into practice a whole-of-government response in terms of research.[23]

Longitudinal studies

5.22 The committee heard that one of the areas of research need was longitudinal studies that were able to provide evidence of causal links, if any, between environmental factors and individual health outcomes. SA Health's Dr Buckett explained the difficulty in researching the social determinants of health:

> It is a very long time frame that we are dealing with in public health so interventions are often quite difficult. Success is much easier with a double-blink clinical trial at the medical end of health, to actually do an intervention, manipulate one particular variable and see an outcome very quickly. So that sort to research gets very much supported, and so it should, but some of the longer term issues and the more difficult and complex issues tend to be seen as too difficult and therefore are not supported for research.[24]

Reporting

5.23 One of the key purposes of conducting ongoing research is to track changes in the health outcomes of the population. St. Vincent's Health recommended to the committee that:

> [T]he No 1 thing we would suggest is allocating responsibility for the health of the community to a part of the healthcare system. To do that we

22 Professor Michael Moore, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, p. 1.

23 Professor Michael Moore, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, p. 1.

24 Dr Buckett, Director of Public Health, SA Health, Committee Hansard, 4 December 2012, p. 22.

> need to set up some KPIs [Key Performance Indicators] so that we are measuring the health of the community and reporting on it publicly.[25]

5.24 ANPHA also emphasised the importance of having a reporting framework established to both track and monitor progress on the social determinants agenda:

> [I]t is absolutely critical to have the reporting, whether we call it that or whether we call it something else—that report across inequitable health outcomes, looking at the real determinants, such as the question of whether people get access to good advice in pregnancy or whether people did not have early childhood education. It is quite critical to bring that together in a single entity as a report—which they do.[26]

5.25 Both ANPHA and Catholic Health Australia[27] discussed the correlation between improvements in indigenous health and regular reporting:

> In the same way you use Closing the Gap here in relation to Indigenous disadvantage, when you have that report, produced in this case by the Productivity Commission through its COAG indicators, repeatedly coming up in front of you then first of all you make sure the invisibility does not occur. When you report in a consistent way with an institution of that econometric and statistical capacity, and you report repeatedly on both the states and territories of the Commonwealth on outcomes which matter and not just reporting, that focuses the minds of governments.[28]

5.26 Ms Sylvan from ANPHA added that while she believed the necessary data on social determinants exists, it is not being brought together in one report to identify linkages, and variation in the language used can make progress difficult to track. Which body is the most appropriate to carry out this task was also discussed:

> …almost all that stuff is sitting there, it seems to me; it is just not gathered in that way. I know that in their submission the AIHW said quite clearly that they were looking forward to contributing to the social determinants questions. Whether it sits there or whether it sits within a COAG or CRC reporting structure, which the Productivity Commission largely does, it needs an entity that can pull the state, territory and Commonwealth information together to report. We have another report that is very important and that is not entirely dissimilar, which is *Measures of Australia's progress*, by the ABS, which is also critical in this space—

25 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 2.

26 Ms Louise Sylvan, Chief Executive Officer, Australian National Health Prevention Agency, *Committee Hansard*, 11 December 2012, p. 5.

27 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 4.

28 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, Committee Hansard, 11 December 2012, p. 3.

> although, again, they do not use the language of social determinants; they use the language of people's progress. [29]

5.27 Dr Batten from St Vincent's Health observed that there needed to be clear responsibility for reporting on social determinants:

> Unless you have one body with the responsibility for collecting the information, collecting the data, having that data reported to it and reporting on the KPIs to see if we are making a difference within the Australian healthcare system then we are going to continue the fragmentation. Does it need to be an entirely separate body? Could it be a body that is subsumed within many of the other systems already created, whether the Australian Institute of Health and Welfare or the Prime Minister and Cabinet's office? I am not saying where it needs to sit, but unless you have a body with that focus to collect that data and to report on the progress being made then we will continue the fragmented approach we have had.[30]

5.28 Catholic Health Australia had a clear idea on how the data should be brought together and how that could be reported on a regular basis:

> Our second recommendation is that on an annual basis the Prime Minister would make a report to the Australian parliament indicating progress against the World Health Organization framework. We have the advantage that the Australian Institute of Health and Welfare has already looked at the World Health Organization framework and has done some of the localisation work that we think is necessary. The Institute of Health and Welfare, the Australian Bureau of Statistics, the Productivity Commission and the Department of the Prime Minister and Cabinet themselves already collect almost all of the data that would be required to report progress on an annual basis against the WHO targets. There is not necessarily a need for new data capture to be facilitated. Rather, there is a benefit of harnessing that data which is already captured, reporting it in one place against a social determinants framework and giving it the profile of a Prime Minister on an annual basis making a report to parliament on progress.[31]

5.29 The Department of Health and Ageing provided the committee with examples of reports currently produced that 'analyse and report…, often against agreed frameworks and indicators, and with consideration of how Australia's social circumstances are changing over time' including:

- Measure of Australia's Progress (Australian Bureau of Statistics);
- How Australia's Faring (Social Inclusion Board);
- Australia's Health (Australian Institute of Health and Welfare);

---

29 Ms Louise Sylvan, Chief Executive Officer, Australian National Health Prevention Agency, *Committee Hansard*, 11 December 2012, pp. 5-6.

30 Dr Batten, Group Chief Executive Officer, St Vincent's Health Australia, *Committee Hansard*, 23 November 2012, p. 7.

31 Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 2.

- Social Health Atlas (Public Health Development Unit);
- Australian Early Development Index (Department of Education, Employment and Workplace Relations); and
- State of Preventive Health (Australian National Preventive Health Agency).[32]

Committee View

5.30 The committee received positive evidence from Professor Baum, amongst others, on current Australian activity around the social determinants of Health agenda:

> Australia already does a lot of things that are very good in terms of social determinants, so that is why we think it is really important that it needs to document what is already being done that is really good and that we would want to maintain and enhance…[33]

5.31 However the committee has not been convinced that this current activity is providing a coherent strategic analysis of the social determinants of health that could inform potential actions to address negative health outcomes. The Marmot review in the UK provided the vehicle and the focus for examining the social determinants of health in that country. The extensive review utilised a vast amount of data to produce a compelling case for reducing health inequalities, and a framework for doing so. The committee does not think that the Australian government has such a focus currently.

5.32 The AIHW discussed ongoing activities undertaken as a result of the government's focus on tackling indigenous disadvantage as part of the closing the gap agenda. Significant efforts have been made to address data gaps that inhibit effective monitoring and reporting, through the establishment of bodies such as the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data. In the committee's view the coordination between agencies such as the ABS and the AIHW, facilitated by a strong political will and concomitant funding, is what is required to achieve a similarly comprehensive and coherent policy outcome for social determinants of health.

5.33 The committee heard that there were significant gaps in the data that needed to be addressed through targeted research. There was a perception that the NHMRC funding in particular was geared towards medical research rather than public health research.

5.34 The committee was surprised to hear that a research event had taken place in September 2012 to discuss the research requirements around the social determinants agenda, yet neither the Department, nor NHMRC themselves had thought it appropriate to inform the committee of this discussion, in spite of it occurring during the committee's inquiry.

---

32 Department of Health and Ageing, *Submission 60*, p. 30.

33 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, p. 18.

5.35 The committee supports an analysis of the priorities of the NHMRC to establish whether there should be a realignment of research priorities to ensure a greater emphasis on public health research, including research into social determinants.

Recommendation 4

5.36 The committee recommends that the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinants research.

5.37 The committee is strongly supportive of a regular reporting framework being established specifically on the social determinants of health. The regular reporting on the *Closing the Gap* agenda to tackle Indigenous disadvantage ensures that a focus on Indigenous disadvantage is maintained, and progress against milestones is assessed at the highest levels within government and in the media.

Recommendation 5

5.38 The committee recommends that annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

Senator Rachel Siewert
Chair