



The History of Indigenous Identification in Victorian Health Datasets, 1980–2011:

Initiatives and Policies Reported by Key Informants

Bree Heffernan — Dulce Iskandar — Jane Freemantle



The Victorian Aboriginal Child Mortality Study, 1988–2008

This report is a component of the Victorian Aboriginal Child Mortality Study (VACMS) – a total population, data linkage, child mortality study currently underway at Onemda VicHealth Koori Health Unit at the University of Melbourne, in conjunction with the Victorian Aboriginal Community Controlled Health Organisation. It is funded by the Australian Research Council, the Victorian Department of Health and the Lowitja Institute. The overall aim of the VACMS is to measure accurately the patterns and trends of Aboriginal infant, child and youth mortality and the disparities between Aboriginal and non-Aboriginal populations in Victoria for births occurring in the 20 years from 1988 to 2008 inclusive.

This five-year study, which commenced in 2009 and will be completed by 2013, will link data from a number of statutory and administrative datasets to produce a complete birth and mortality profile for Aboriginal (and non-Aboriginal) infants, children and young people in Victoria born between 1988 and 2008 (www.vacms.net.au).

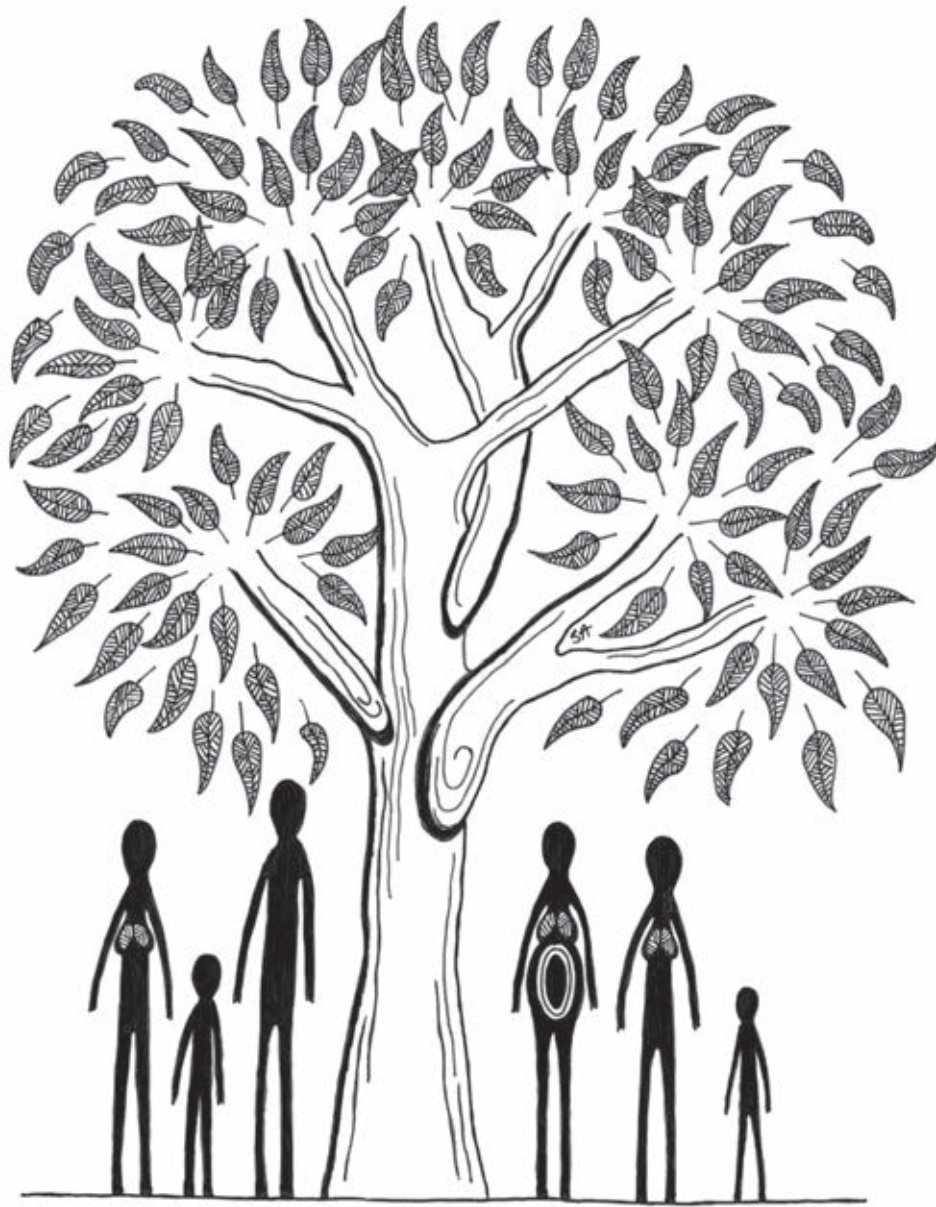
The project consists of four phases:

1. record linkage between the datasets containing birth information to obtain an accurate and complete identification of Aboriginal births, and appending of perinatal information describing all births in Victoria to the linked dataset;
2. coding of all deaths, validation of the cause of death coding, development of a preventability index and linkage of the validated and coded deaths data to the perinatal dataset;
3. analysis of the birth and death data; and
4. preparation of a report that describes the patterns and trends of Victorian births and deaths, and disparities between Aboriginal and non-Aboriginal children born 1988 to 2008.

Phases 1 and 2 are currently underway. Phase 1 of the VACMS will result in more complete and accurate data describing Aboriginal and Torres Strait Islander births in Victoria over a 20-year period. The VACMS involves the matching of statutory and administrative data sources to produce a database of validated Victorian Aboriginal (and non-Aboriginal) births between 1988 and 2008 inclusive, and infant, child and youth deaths for the period 1988 to 2009 inclusive.

An understanding of the integrity of the data and the processes for acquiring access to these data was an essential first step in this process, and in 2009 resulted in the first report from the VACMS, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria's Aboriginal Infants, Children and Young People*. This report aimed to provide a better understanding of how accurately and completely administrative and statutory datasets collect data on infant, child and young people's health, with a specific reference to the recording of Indigenous status.

To interpret the birth and death rates reported in the VACMS, investigators needed to understand external and possible artefactual influences on fluctuations in the number of Aboriginal and Torres Strait Islander-identified births and deaths during the study period. Due to the relatively small number of Aboriginal births and deaths each year in Victoria, the recorded numbers would be most susceptible to the influence of initiatives implemented to improve Indigenous identification. This report aims to collate such policies and initiatives in chronological order to help investigators and readers understand possible artefactual influences on these data.



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This image represents 'connections' and their relevance to health and wellbeing. Our connections with mother earth and the natural world keep us well and our connections with one another through family and community heal us and keep us whole.

Shawana Andrews



An Australian Government Initiative





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List of Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AHLO	Aboriginal Hospital Liaison Officer
AHLOC	Aboriginal Hospital Liaison Officer Collection
AIHW	Australian Institute of Health and Welfare
ALO	Aboriginal Liaison Officer
RBDM	Registry of Births, Deaths and Marriages
CCOPMM	Consultative Council on Obstetric and Paediatric Mortality and Morbidity
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DHS	Department of Human Services (Victoria)
DoH	Department of Health
DoJ	Department of Justice
GP	General Practitioner
HCV	Health Commission of Victoria
ICAP	Improving Care for Aboriginal Patients
KMHLO	Koori Mental Health Liaison Officer
PRISM	Program Report for Integrated Service Monitoring
RBDM	Registry of Births, Deaths and Marriages
SES	Socioeconomic status
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VACMS	Victorian Aboriginal Child Mortality Study
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VPDC	Victorian Perinatal Data Collection
WIES	Weighted Inlier Equivalent Separation





Executive Summary

The 'gap' in the social determinants of health between Aboriginal and Torres Strait Islander (herein referred to as Aboriginal)¹ and non-Aboriginal populations in Victoria continues to be a significant concern to the community, and to State and Federal policy makers. Robust methods are needed to measure progress towards reducing this gap and to assessing the impact of strategies, policies and practices aimed at reducing the disparities in health outcomes experienced by Aboriginal people. These methods rely on accurate statutory and administrative health data, and birth and death registrations. Accurate and complete identification of Aboriginal people in datasets enables evidence-based decision-making and evaluation of the effectiveness of initiatives aimed at reducing the 'gap' in health outcomes.

The issue of under-identification of Aboriginal people in statutory and administrative datasets in Victoria is widely publicised. This report, which is part of the Victorian Aboriginal Child Mortality Study (VACMS), 1988–2008, provides the first comprehensive record of initiatives implemented over the past 30 years to address this issue. It also reports on the knowledge and experience of key informants who have worked/continue to work in the area of Aboriginal data collection, policy development and evaluation, and data custodianship.

The report includes an analysis of informant responses with regards to barriers to Indigenous identification, both collectively and by specific informant group, including the significance of these barriers to identification commonly reported in State and Federal publications. All responses are summarised in Appendix C.

The aim of this project was to build a comprehensive record of initiatives implemented to improve Indigenous identification in Victoria over the past 30 years. Further, the information has the potential to inform the analyses of Aboriginal (and non-Aboriginal) health data by exploring how annual changes in Indigenous-identified births, deaths and admissions to public hospitals align with key initiatives implemented to improve Indigenous identification.

The study employed a mixed methods design, which included a review of academic and public policy literature and face-to-face semi-structured key informant interviews (the latter were transposed into quantitative data through thematic analysis). In addition, a supplementary analysis of the relationship between the available annual Indigenous birth and hospitalisation data held by the Department of Health (DoH) and the timing

¹ The authors consulted Angela Clarke, Deputy Director (Community Programs) and Lecturer in Community Development at the Onemda VicHealth Koori Health Unit, The University of Melbourne, with regards to the appropriate terminology to respect the Aboriginal and Torres Strait Islander population for the purposes of this report. Hence, throughout this report the Aboriginal and Torres Strait Islander population is referred to as the 'Aboriginal' population. When referring to 'identification' and 'status/identifier' in statutory and administrative data collections, the term 'Indigenous' is used as it relates to Aboriginal and Torres Strait Islander people.



of key initiatives implemented to improve Indigenous identification in these datasets was undertaken.

Results of this study are presented in the order in which they were asked of informants. The questions were grouped under three topics:

- Topic 1: Barriers to Indigenous identification
- Topic 2: Initiatives and policies implemented to improve Indigenous identification
- Topic 3: Recommendations for future policy focus and key stakeholders.

The Results section of this report, also includes an analysis of the number of Indigenous-identified births and hospitalisations and the annual variation of these numbers. The results provide an opportunity to view these initiatives and policies in the context of the changing numbers in births and hospitalisations identified in the Victorian Admitted Episodes Dataset (VAED), Victorian Perinatal Data Collection (VPDC), and the Registry of Births, Deaths and Marriages (RBDM) (births).

The Discussion and Recommendations sections are followed by three appendices. Appendix A includes the final Schema of Initiatives and policies reported by respondents as having been implemented to improve Indigenous identification in Victorian health datasets. This appendix includes a list of links and attachments that correspond with the initiatives in the schema. Appendix B includes the invitation to participate in the study, the plain language statement, consent form and key informant questionnaire. Appendix C provides a summary of key informant responses to each of the questions.

Key findings

Topic 1: Barriers to Indigenous identification

The key barrier to accurate recording of Indigenous identification reported by key informants in this study related to the question of Indigenous status actually being asked by staff (at hospital registration and when registering a birth or death). This was identified as being more valid than the propensity of an Aboriginal person to self-identify Indigenous status when asked or when completing a form. This distinction was consistent irrespective of informant 'type' (Aboriginal Liaison/hospital staff or government/policy/academic informant).

The majority of informants rated the response 'staff member guesses Indigenous identity based on appearance' as highly valid (63.6%), followed equally by 'Indigenous question is not asked by staff at registration' (54.5%) and 'staff member doesn't know why the question should be asked' (54.5%). A small percentage of informants (9.1%) believed the response 'question is not asked by staff' had low or no validity.

The barriers 'a language barrier exists between staff and patient' (70%), 'staff member is too busy to ask all questions' (45%) and 'person chooses not to declare their Indigenous status on a form' (33%) were considered of little or no relevance to accurate identification by informants.

When disaggregated into two informant groups (Aboriginal Liaison/hospital staff, and policy/government/academic staff), there was good agreement between the two groups of informants that 'staff guess Indigenous identity based on appearance', 'staff member doesn't know why the question should be asked' and 'question is not asked by staff at registration' were highly valid barriers to accurate identification.

This agreement was further emphasised when informants were asked about their personal experiences of identification when accessing



a health service or registering a birth or death. Few informants reported that they had been asked their Indigenous status by staff in these instances, despite most Indigenous informants reporting that they had never withheld their Indigenous status when asked and that they were 'very proud' to identify.

Topic 2: Initiatives and policies implemented to improve Indigenous identification

Schema of Initiatives and policies implemented to improve Indigenous identification, 1980–2011

There have been extensive efforts to improve the identification of Indigenous patients, newborn infants and deceased persons over the past three decades in Victoria. Informants were able to recall many varied initiatives implemented with the aim of improving Indigenous identification in Victoria over the past three decades. These are reported in the Schema of Initiatives (and policies) implemented to improve Indigenous identification, 1980–2011 (Appendix A).

Key informant views:

- Ninety-four per cent of informants rated data collection training (as distinct from cultural awareness training) of high importance to improving Indigenous identification (Questions 3, 5, 8 and 10).
- The Schema of Initiatives identified that education programs have been infrequently implemented, in varying forms and by a variety of stakeholders, over the past three decades.
- Both groups of informants acknowledged the employment of Aboriginal Hospital Liaison Officers (AHLOs), system enhancements, and routine feedback by government to health services and community organisations using the data collected as highly important.
- Informant responses identified some confusion regarding responsibility for the delivery of training. Based on DoH

literature, responsibility appears to be shared between DoH (and the preceding Department of Human Services (DHS) and individual hospitals.

- In the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan*, the State government committed to work with 'local hospitals in providing targeted training on data recording, identification of Indigenous status and management to improve data collection' (Victorian Department of Health).²
- The results of this study support data collection training for frontline staff as a leading priority in future efforts to improve Indigenous identification.
- There was a marked inconsistency in opinions regarding the importance of financial incentives (predominantly the hospital Aboriginal Weighted Inlier Equivalent Separation [WIES] supplement) in improving Indigenous identification. Likewise, inconsistency in opinions regarding the importance of strong relationships between health services and Aboriginal Community Controlled Health Organisations (ACCHOs) to improving Indigenous identification was also observed.
- More than 70% of informants in each group regarded 'routine feedback provided by government to health services and community organisations using the data collected' of high importance to achieving accurate identification. Informants commented that feedback was 'an important indicator of Aboriginal people's access to mainstream services', that 'feedback to organisations is critical' and that 'we need more of it'. Conversely, in reference to the RBDM datasets, one informant commented that the RBDM 'should not do any community profiling— it is appropriate to give data back in other circumstances'.

² *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan*, Victoria. Accessed 12 January 2012 at: <www.Federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous/closing_the_gap_health_outcomes/VIC.pdf>.



- Staff training and the employment of AHLOs and Aboriginal staff were the most frequently cited effective initiatives implemented since 1980 to improve Indigenous identification (Question 5). Promotional activities, community engagement and education, accountability and accreditation were the initiatives reported as being the least effective methods for improving the accuracy of Indigenous identification in administrative and statutory datasets.
- Although the Improving Care for Aboriginal Patients (ICAP) program was only explicitly mentioned six times, the program encompasses many other initiatives, such as the employment of AHLOs, Aboriginal artwork, promotional materials, financial incentives (WIES) and staff training. Therefore, the combined support for these initiatives is also attributable to the ICAP program.
- Thematic analysis of local initiatives reported produced four themes: Education and support material, partnerships, data validation and quality assurance, and cultural acknowledgment and safety.

Evaluations of initiatives and policies implemented to improve Indigenous identification

This study found limited existence and/or knowledge of evaluations of initiatives and policies implemented to improve Indigenous identification.

Informants reported evaluation activity at a site and State-wide level (reported in response to Question 6 and summarised in Appendix C). The evaluation of the ICAP program was mentioned most frequently by informants. Other examples included the Australian Institute of Health and Welfare (AIHW) hospital Indigenous identification audits conducted in 2007 and 2011, local analysis of inpatient numbers, pre-/post-training participant evaluation forms and validation of data in one dataset when compared with data in another. A number of other program evaluations were mentioned

for programs that do not have a priority for improving identification but might impact laterally on veracity of identification nonetheless.

Analysis of the number of, and annual variation in, Indigenous-identified births and hospitalisations, and potential correlation with key initiatives and policies in the VAED, VPDC and RBDM (births)

One of the initial aims of this project was to provide a context within which to consider fluctuations in births/hospitalisations identified as Indigenous in statutory and administrative datasets. The question was, essentially, ‘are increases in the number of Indigenous births/hospitalisations true increases, or do they reflect the impact of initiative/s implemented to improve Indigenous identification?’

However, while providing an opportunity to consider possible relationships between initiatives/policies/incentives and fluctuations in Indigenous birth/hospitalisation numbers, direct associations between these events and data could not be drawn. The authors note that the exclusion of local initiatives from the State-wide Schema of Initiatives that may have had an impact on Indigenous hospitalisations recorded, the concurrent implementation of initiatives in a year, and the unknown actual number of births/hospitalisations, prevented a complete evaluation of the association of initiatives on improving Indigenous identification in Victorian administrative and statutory datasets.

Importance of key stakeholders/groups in future efforts to improve Indigenous identification

‘Data collection staff’ were rated of high importance in future efforts to improve Indigenous identification by 94% of responders, followed by ‘managers of data collection staff’ (91%) and ‘Aboriginal Liaison Officers’ (85%). The stakeholders rated of high importance least often were hospital Health Information Managers and the federal government (equally 64%).



Factors occurring outside the health system impacting on a person's willingness to identify

All informants reported that they believed factors outside the health system impacted on an Aboriginal person's willingness to identify (100%). Thematic analysis of factors identified by informants resulted in 11 common themes (see Question 7 and Appendix C). Interaction with, or fear of interaction with, government agencies and programs, and previous government policies including child removal and cultural safety within health services, were the predominant external influences precluding Indigenous identification cited by respondents.

Topic 3: Recommendations for future policy focus and key stakeholders

Eight recommendations for improving Indigenous identification in Victorian health datasets have been identified based on the results of this study.

- **Recommendation 1:** To develop a coordinated, long-term strategy specifically for staff training in the collection of Indigenous identification data across datasets and sectors targeting frontline registration staff e.g. hospital registration staff, ward clerks, midwives and funeral directors, including the development of a comprehensive strategy evaluation framework at the commencement of this activity.
- **Recommendation 2:** To review the role and distribution of AHLOs in public hospitals across Victoria, particularly their role in improving the collection of Indigenous status information, and increase AHLO staff where appropriate to support the needs of Aboriginal patients.
- **Recommendation 3:** That DoH continues to actively promote the new indicators regarding Aboriginal health in Program Report for Integrated Service Monitoring (PRISM) reports and the sharing of this information with those with responsibility for Aboriginal health.

That the collection and reporting of these data are evaluated for relevance and application with key stakeholders (e.g. management, AHLOs and DoH stakeholders).

- **Recommendation 4:** That the DoH provides clarification regarding health services' level of accountability for reporting and re-allocating the nominal Aboriginal WIES supplement generated by identified patients in their health service in Aboriginal initiatives and programs.
- **Recommendation 5:** That future initiatives and policies implemented to improve Indigenous identification include an evaluation strategy to measure efficacy and impact and guide future work/investment locally and at a State and national level.
- **Recommendation 6:** That health services and data custodians review current processes for recording Indigenous identification in administrative and statutory data and implement best practice processes for validation of collected data.
- **Recommendation 7:** That government agencies and health services continue to develop point-of-identification posters and pamphlets to emphasise the importance of asking and answering the Indigenous status question and how the information is used.
- **Recommendation 8:** That DoH continues to hold health services accountable for the receipt of the Aboriginal WIES supplement through reporting in Quality of Care reports. And that opportunities continue to be explored for linking clinical accreditation with demonstrated knowledge and recording of accurate Indigenous identification.

These recommendations should be considered by policy makers, data custodians and health service management in the development of policies and strategies to improve the identification of Indigenous status in statutory and administrative health datasets.



General points for discussion

The importance of Indigenous identification

This study has further highlighted a distinction between the importance of Indigenous identification in mainstream acute public health service settings and in birth and death registrations.

Accurate and complete Indigenous identification in hospital/perinatal data is vital to ensuring the development and implementation of evidence-based and targeted healthcare, policies and practices. This information informs Aboriginal Liaison staff of an admission of an Aboriginal person and thus ensures appropriate services and care are provided. Accurate administrative patient data are also vital for ensuring adequate and appropriate resourcing of services, programs and policies focusing on improving primary health care services for Aboriginal Victorians.

Identification in birth and death registration data is vital in the provision of proof of identity documents, which enable complete participation in societal activity. Accurate data are also vital in monitoring population vital statistics through providing an accurate denominator to enable the calculation of rates in public health statistics.

Sources of Indigenous identification

Although the national definition applies to all statutory and administrative datasets, this study revealed that the source of identification of an individual differs over the life course. In some instances it is provided by the individual and in others it is provided by a third party, commonly a parent or next of kin.

As suggested by one informant in this study, there is potential for a third party's views and beliefs to influence the identity of a deceased person in a death record. Such discrepancies between an individual's connection with his or her identity or Indigenous descent and the views of a third party may be the result of the informant not being aware of, or not fully

understanding or supporting, the individual's identity at the time of death.

As an extension of this discussion, one informant raised a query regarding the legitimacy of the national definition (based on a High Court judgment in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625), which includes self-identification as a critical component of the definition, along with descent and community acceptance.

The differing sources of identification support an argument for the use of data matching/linkage from multiple data sources to provide a more accurate and complete picture of the Indigenous population, births, deaths and use of health services than data extracted from one data source in isolation. Data linkage is an important tool in the validation of Indigenous identification across datasets.

The role of data matching/linking in Indigenous identification

The results of this study also provide a persuasive argument for the use of matching/linking data at an individual level using multiple data sources to provide a more accurate and complete picture of the Indigenous population rather than data extracted from one data source in isolation. The matching of multiple data sources and application of an 'ever-identified' rule would provide a more complete representation of the Aboriginal and Torres Strait Islander population.

The results of this project will provide a valuable context within which to more accurately interpret the 20 years of linked total population Victorian birth data to be undertaken as Phase 1 of the VACMS. Fluctuations in the number of Aboriginal births will be considered in the context of the timing of implementation of major initiatives outlined in the Schema of Initiatives (Appendix A). Phase 1 of the VACMS will also provide a comprehensive, 20-year report on the percentage of Aboriginal Victorians who identify as Indigenous through the birth registration process.





Introduction

Universally, health and vital statistics have an important public health function. They provide a base from which to monitor the incidence and distribution of disease, and births and deaths in and between populations. They also provide evidence to inform policy and prevention programs, to clarify government priorities, to monitor service delivery, and to form a base from which to measure the impact of initiatives implemented with the aim of reducing morbidity and mortality.³ Better information facilitates better decision-making.

Importantly, in a hospital setting, Indigenous identification signals to Aboriginal support staff that an Aboriginal patient has been admitted to the hospital and may require support and access to specialist services in order to achieve the best possible quality of care and health outcomes. At this local level, accurate health data enable assessment of the effectiveness and responsiveness of health services to the needs of their clients and community. These data can also be a valuable tool for community groups in advocating for policy change and holding governments accountable for expenditure and delivery on political promises.⁴

These data are also used to monitor and report on Indigenous health in an international context, applying an additional degree of political accountability to Federal governments.⁵ Human rights discourse argues that 'governments have an international obligation to take proactive steps to improve the health and wellbeing' of 'minority, disadvantaged and marginalised population groups'.⁶ These principles are expressed as a universal right to the opportunity to lead a healthy life, including equal access to quality care and the underlying social determinants of health.⁷

Indigenous identification

Monitoring the numbers of births and the rates and cause/s of morbidity and mortality in Indigenous people, and access to health care, is made possible through the identification of a person/patient's Indigenous status in datasets such as birth, hospital and death collections/registries, health surveys and population censuses. The Indigenous status field in hospital patient records, perinatal birth reports and birth registrations dictates whether an individual's information is aggregated into the 'Indigenous' or 'non-Indigenous' category for monitoring and reporting at site, State and national levels.

³ G. K. Draper, P. J. Somerford, A. S. Pilkington & S. C. Thompson 2009, 'What is the impact of missing Indigenous status on mortality estimates? An assessment using record linkage in Western Australia', *Australian and New Zealand Journal of Public Health*, vol. 33, no. 4, pp. 325–31.

⁴ I. Barnsley 2006, 'The right to health of Indigenous peoples in the industrialized world: A research agenda', *Health and Human Rights*, vol. 9, no. 1, pp. 43–54.

⁵ *ibid.*

⁶ N. Gray & R. Bailie 2006, 'Can human rights discourse improve the health of Indigenous Australians?', *Australian and New Zealand Journal of Public Health*, vol. 30, no. 5, pp. 448–52.

⁷ *ibid.*



This information is collected from the person/patient using a standard question prescribed by the Australian Bureau of Statistics (ABS). This standard prescribes that every Australian-born person admitted to hospital or who gives birth with the assistance of a midwife, or who registers a birth with the RBDM, should be given the opportunity to identify his or her Indigenous status.^{8,9} This question should be asked by clerical staff when a person is admitted to hospital, by a midwife when completing a Birth Report Form, and/or self-reported by an individual when completing an admission or birth registration form.¹⁰

In response to the question 'Are you [the person] of Aboriginal or Torres Strait Islander origin?', the respondent's answer is recorded as either:

- a. No
- b. Yes, Aboriginal, and/or
- c. Yes, Torres Strait Islander.^{11,12}

In the AIHW *National Health Data Dictionary*¹³ a more detailed list of responses is documented for datasets. These additional responses are mapped back to the three documented in the ABS national standard for reporting.¹⁴

Responses to the question of Indigenous status in the *National Health Data Dictionary* are as follows:

- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal
- Both Aboriginal and Torres Strait Islander origin
- Neither Aboriginal nor Torres Strait Islander origin
- Not stated/inadequately described.¹⁵

The Commonwealth definition of an Aboriginal and/or Torres Strait Islander person used in many administrative and statutory datasets is based on a High Court judgment in the case of *Commonwealth vs Tasmania* (1983) 46 ALR 625:

*An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.*¹⁶

Thus, there are three components to the Commonwealth definition:

- descent
- self-identification
- acceptance by the community.¹⁷

⁸ AIHW 2006, *The ABS Standard Question on Indigenous Status*, AIHW, Canberra. Accessed 13 January 2010 at: <www.aihw.gov.au/indigenous/national_standards/abs_standard.cfm>.

⁹ DHS 2008, *Koori Health Counts! 2006/07*, DHS, Melbourne.

¹⁰ B. Heffernan, S. Sheridan & J. Freemantle 2009, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria's Aboriginal Infants, Children and Young People*, The University of Melbourne.

¹¹ ABS 1999, *Standards for Statistics on Cultural and Language Diversity*, ABS, Canberra.

¹² AIHW 2006, *The ABS Standard Question on Indigenous Status*, AIHW, Canberra. Accessed 18 March 2009 at: <www.aihw.gov.au/indigenous/national_standards/abs_standard.cfm>.

¹³ Health Data Standards Committee (HDSC) 2008, *National Health Data Dictionary: Version 14*, AIHW, Canberra.

¹⁴ *ibid.*

¹⁵ N. Gray & R. Bailie 2006, 'Can human rights discourse improve the health of Indigenous Australians?', *Australian and New Zealand Journal of Public Health*, vol. 30, no. 5, pp. 448–52.

¹⁶ AIHW 2006, *The ABS Standard Question on Indigenous Status*, AIHW, Canberra. Accessed 18 March 2009 at: <www.aihw.gov.au/indigenous/national_standards/abs_standard.cfm>.

¹⁷ *ibid.*

However, in practice, in most general purpose statistical and administrative collections it is not feasible to determine whether a person is accepted by his or her community as an Indigenous person. Therefore, the standard question of Indigenous status in these health datasets relates to descent and self-identification rather than community acceptance, a biological blood quantum or ancestral *degree* of Aboriginality. There is no requirement to provide 'proof' of descent when identifying in these collections.

The situation is slightly different when registering a birth or death in the VPDC or the RBDM. Although the Commonwealth definition still applies, Indigenous status is not provided by the individual, but by a third party, commonly a parent, spouse or family member. Because newborn infants and deceased persons do not have the capacity to answer the question of Indigenous status, the question is answered by the attending parent or next-of-kin.

Under-identification of Indigenous status

The disproportionate health status of Aboriginal and Torres Strait Islander compared to non-Aboriginal and Torres Strait Islander Australians has gained significant political attention in recent years. This has resulted in a strengthened commitment by State and Federal governments to improve equity in health nationally and at a State level. This commitment was formalised in the Council

of Australian Governments' (COAG) 'Close the Gap' campaign, which was endorsed by the Federal Government, the Victorian State Government and Aboriginal community representatives.

Prime Minister Julia Gillard, in her 2011 annual Closing the Gap speech to Federal Parliament, said:

I see Closing the Gap as a way of understanding the problems. It is evidenced-based, accountable and transparent. It tells us what needs to be done first and fastest and builds a methodical approach. It allows us to build consensus in support of specific progress, instead of debating abstract ideas. To do what we can, with what we have, where we are... It is a way of making specific, measurable progress... It gives us new information which means we can be sure the government is meeting its responsibilities.

Although the Closing the Gap initiative has gained increasing political attention, so too have the shortcomings of Indigenous health data used to measure progress towards the initiative's goals. In response to the Prime Minister's speech, Opposition Leader Tony Abbott called for '*more rigorous monitoring of efforts to reduce disadvantage and more aggressive targets*', commenting that the Prime Minister's report '*failed to paint a clear picture of how fast things were changing, especially in the target areas of health and education*'. Mr Abbott commented '*that this is largely because of the inadequacy of existing statistics; a shortcoming Ms Gillard said was being addressed*'.¹⁹

¹⁸ *Australian* 2011, 'PM's Closing the Gap speech on Indigenous Australia, in full', 9 February. Accessed 18 January 2012 at: <http://www.theaustralian.com.au/national-affairs/pms-closing-the-gap-speech-on-indigenous-australia-in-full/story-fn59niix-1226002750396>

¹⁹ M. Gordon 2011, 'Indigenous gap unclear in snapshot', *Age*, 10 February. Accessed 18 January 2012 at: <http://www.theage.com.au/national/indigenous-gap-unclear-in-snapshot-20110209-1an35.html>



Prior to 1976, no Australian jurisdiction separately identified Indigenous people in vital statistics or hospital-based collections.²⁰

The question of Indigenous status was introduced in Victorian datasets in the years outlined in Table 1 (below).

Table 1: Year of introduction of the ‘Indigenous status’ variable in key statutory and administrative health datasets in Victoria

Year	Dataset
1982	Victorian Perinatal Dataset
1986	Victorian Admitted Episodes Dataset (made mandatory in 1993)
1986	Victorian Registry of Births
1986	Victorian Registry of Deaths (Death Notification Form and Medical Certificate of Death)
1988	Aboriginal Hospital Liaison Officer Collection (commenced official data collection)

The issue of under-identification of Indigenous status in Victorian health datasets is a longstanding concern referenced in many AIHW, ABS and government reports, and peer-reviewed journal publications.²¹ In some datasets the degree of inaccuracy is unknown, in some it is presumed to be accurate but not tested and, in others, data are accurate but by no means complete.²²

In a 2009 VACMS report, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria’s Aboriginal Infants, Children and Young People*, data custodians were asked how confident they were of the accuracy of Indigenous status data in their datasets.²³ Table 2 (see next page) provides a summary of responses provided by data custodians.



²⁰ B. Heffernan, S. Sheridan & J. Freemantle 2009, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria’s Aboriginal Infants, Children and Young People*, The University of Melbourne.

²¹ *ibid.*

²² *ibid.*

²³ B. Heffernan, S. Sheridan & J. Freemantle 2009, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria’s Aboriginal Infants, Children and Young People*, The University of Melbourne.

Table 2: Responses to the question ‘How confident are you that the Indigenous status is accurate?’ by dataset²⁴

Dataset	Unsure/ varies	Not confident	Confident	Very confident	Other/comments
Aboriginal Hospital Liaison Officer Collection				✓	Very confident from 1988. There is a high degree of confidence in the accuracy of Aboriginal identification in data submitted by AHLOs. Confidence in the level of coverage varies depending on the submitting hospital; the location and size of the hospital and the AHLOs period/s of leave.
VPDC	✓				Unsure.
VAED	✓				Confidence varies depending on the collecting hospital. The coverage of Aboriginal status tends to vary depending on the size of the local Aboriginal population and geographic area.
RBDM (births)			✓		Information is provided by the child’s parents and is presumed to be accurate. Further information is sought if there is a reason to query the data.

In Victoria birth collections and registers are believed to underestimate the true number of Aboriginal births²⁵ and therefore underestimate adverse birth outcomes such as low birth weight, pre-term birth, teenage pregnancy and perinatal mortality.

Table 3 (see next page) was published in the *Koori Health Counts! 1999–2008/9* publication series. It demonstrates the inconsistent recording of Indigenous births between datasets over time, at least partially due to

differing classification of Aboriginal births (those born to Aboriginal mothers versus Aboriginal mothers and/or fathers). Over the decade 1999–2008/09 the RBDM registered 2247 more Aboriginal births than the VPDC. Aboriginal births registered in the VAED and VPDC more closely aligned, potentially in part due to the fact that most births occur in hospital and there may be some sharing of demographic information between the two sources.

²⁴ *ibid.*, p. 33.

²⁵ DHS 2008, *Aboriginal Services Plan Key Indicators 2006/07*, DHS, Melbourne.



Table 3: Indigenous births by dataset and year, Victoria, 1999–2008/09²⁶

Data source	1999	2000	2001	2002	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Total
VAED— Births to Aboriginal mothers only	363	333	379	411	n/a	433	502	589	684	752	4,446
AHLO—Total Aboriginal births (in select public hospitals)	353	303	363	299	310	397	449	550	n/a	n/a	3,024
VPDC— Births to Aboriginal mothers only	452	377	421	416	362	435	538	569	698	727	4,995
RBDM— Total Aboriginal births	521	452	522	601	722	719	802	782	1,025	1,096	7,242

From a national perspective, the ABS reports that the identification of Indigenous status in deaths registered in south-eastern jurisdictions is not sufficiently complete, nor is the number of identified Indigenous deaths large enough to produce reliable coverage or life expectancy estimates.²⁷ The life expectancy ‘gap’ cannot currently be calculated for Victoria individually.²⁸ There are a number of factors widely believed to contribute to the misclassification and under-reporting of Indigenous status in health datasets.²⁹

Also, a number of underlying reasons have been suggested to explain the failure of

administrative personnel to ask and record a person’s Indigenous status, and an Aboriginal person/patient’s choice not to self-identify. These include:

Inconsistent application of the agreed national standard for asking the question of Aboriginal or Torres Strait Islander origin, inadequate staff training in the task of data collection, a lack of staff awareness as to the importance of collecting accurate information, staff concerns about negative reactions to the Indigenous status question from Aboriginal and non-Aboriginal respondents, and a belief that Aboriginal patients feel disinclined to acknowledge their Aboriginality when the question is asked in an inappropriate way.³⁰

²⁶ DHS 2008, *Koori Health Counts! 2006/07*, DHS, Melbourne; DoH 2011, *Koori Health Counts! 2009–10*, DoH, Melbourne. Victorian Aboriginal hospital data 2007–08 to 2008–09.

²⁷ ABS 2008, *Discussion Paper: Assessment of Methods for Developing Life Tables for Aboriginal and Torres Strait Islander Australians Australia 2006*, ABS Cat. No. 3302.0.55.002, ABS, Canberra.

²⁸ B. Heffernan, S. Sheridan & J. Freemantle 2009, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria’s Aboriginal Infants, Children and Young People*, The University of Melbourne.

²⁹ AIHW 2005, *Improving the Quality of Indigenous Identification in Hospital Separations Data*, Health Services Series No. 25, AIHW Cat. No. HSE 101, AIHW, Canberra.

³⁰ B. Heffernan, S. Sheridan & J. Freemantle 2009, *An Overview of Statutory and Administrative Datasets: Describing the Health of Victoria’s Aboriginal Infants, Children and Young People*, The University of Melbourne, p. 5.



A number of other Victorian studies supported these theories.^{31,32,33}

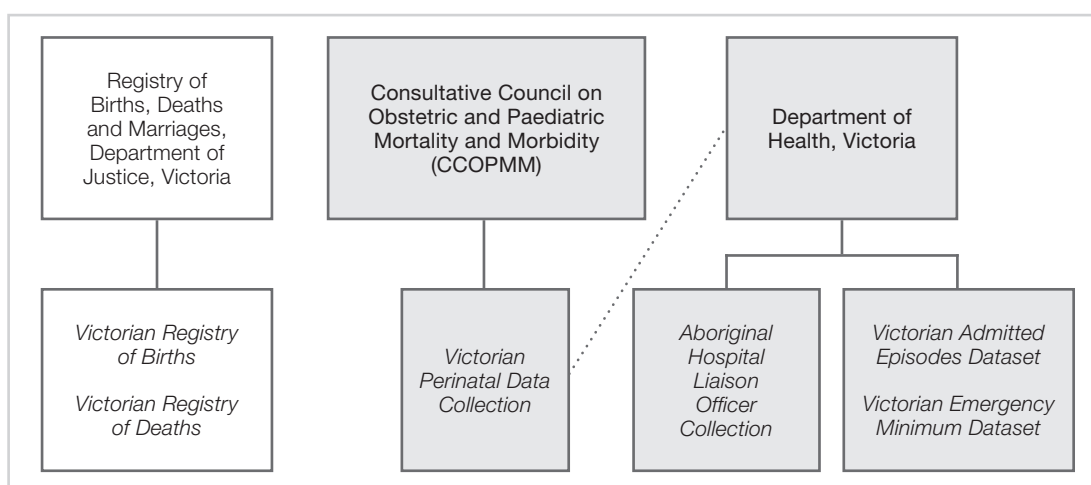
In 2001–02, information provided by AHLOs identified a 22% ‘undercount of separations for Indigenous persons in Victoria’.³⁴ In 2010, AIHW published results from the Indigenous Identification Project conducted in each jurisdiction to test the estimated degree of under-identification in public hospital inpatient data. The report identified that 84% of Indigenous patients were correctly recorded in the study, representing an under-count of 16% (based on a sample of 1100 bedside patient interviews cross-checked with patient records).³⁵ This study followed the 1988 pilot project, where the results from Victoria led to the decision to exclude future hospital

data from Victoria in national reporting. This directive was rescinded in 2010.³⁶

Sources of statutory and administrative birth, death and hospitalisation data in Victoria

Four statutory and administrative datasets record population birth and death data in Victoria: VPDC, VAED, RBDM and the Aboriginal Hospital Liaison Officer Collection (AHLOC). These are managed by two government departments (DoJ and DoH) and a ministerial-appointed statutory body, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) (see Figure 1 below). Key informants were asked to identify which datasets their knowledge related to and answer questions in the questionnaire accordingly.

Figure 1: Data custodians and population vital statistics datasets in Victoria, 2010



³¹ T. Owen 1999, *Indigenous Identification in Victorian Birth Records: 1996/97*, DHS, Melbourne.

³² H. Robertson, J. Lumley & S. Berg 1995, 'How midwives identify women as Aboriginal or Torres Strait Islanders', *Australian College of Midwives Incorporated Journal*, vol. 8, no. 3, pp. 26–9.

³³ T. Owen 1999, *Indigenous Identification in Victorian Birth Records: 1996/97*, DHS, Melbourne.

³⁴ AIHW 2010, *Indigenous Identification in Hospital Separations Data—Quality Report*, Health Services Series No. 35, Cat. No. HSE 85, AIHW, Canberra, p. 5.

³⁵ *ibid.* p.23.

³⁶ *ibid.*



Aims

The aims of this study were to:

- document the policies and initiatives implemented with the aim of improving the identification of Aboriginal and Torres Strait Islander people in Victorian health datasets since 1980
- record the views and knowledge of key informants regarding the barriers and enablers to accurate Indigenous identification, key policies and initiatives implemented since 1980, and key areas of focus for the future
- explore if any conclusions can be formed regarding the efficacy of initiatives implemented to improve Indigenous identification based on an analysis of the number of Indigenous-identified births and hospitalisations recorded in each dataset compared to the timing of key initiatives and policies.

To interpret the birth and death rates reported in the VACMS, investigators needed to

understand external and possible artefactual influences on fluctuations in the number of Indigenous-identified births and deaths during the study period. Due to the relatively small number of Aboriginal births and deaths each year in Victoria, the recorded numbers would be most susceptible to the influence of initiatives implemented to improve Indigenous identification. This report aims to collate such policies and initiatives in chronological order to help investigators and readers better understand possible artefactual influences on these data.

In addition to providing a valuable snapshot of efforts to improve Indigenous identification over the past 30 years, the authors aimed to correlate the annual fluctuations observed in the number of Indigenous births and deaths in health and vital statistic datasets with implemented initiatives to inform the knowledge-base of what works (or does not work) to improve Indigenous identification in statutory and administrative health datasets.





Method

This study employed a mixed methods design that included the review of academic and public policy literature and face-to-face semi-structured key informant interviews. The latter were transposed into quantitative data through thematic analysis.

Importantly, a supplementary analysis of the possible correlation between annual Indigenous birth and hospitalisation numbers and the timing of key initiatives implemented to improve Indigenous identification in these datasets was undertaken.

Ethics approval

Ethics approval was obtained for this study from The University of Melbourne Human Research Ethics Committee prior to contacting informants or conducting the work.

Literature review and questionnaire development

Literature review

The first step of the process was to undertake a literature review of policies and initiatives and programs introduced since 1980, to improve Indigenous identification in each of the four datasets of interest. A Schema was developed to capture data on initiatives that had the potential to have impacted on identification in these datasets. Advice from the ABS and the AIHW contributed to the Schema of Initiatives.

The desktop search strategy included targeted peer-reviewed literature, using Internet search engines (including PubMed, Medline) and key websites (such as DoH, ABS, AIHW, Indigenous Health/InfoNet). A comprehensive Endnote library was established.

The literature review informed some of the questions in the questionnaire, particularly Questions 2.1, 4 and 9, where informants were asked to rate the validity/importance of barriers, policies and stakeholders identified in the literature.

Questionnaire development

The questionnaire was developed to capture factual information on initiatives and policies implemented since 1980, and to elicit informants' views with regards to barriers and enablers to Indigenous identification in datasets, the success of past initiatives and, based on their professional and personal perspectives, recommendations for future initiatives. The questionnaire was a combination of free text fields and pre-determined multiple choice questions.

The questionnaire was piloted among six participants from the Onemda VicHealth Koori Health Unit and units of DoH (Victoria).

The pilot group included Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander participants, representing a variety of professional positions and community perspectives. The questionnaire



was continually amended in response to the pilot consultations. The final questionnaire was referred back to the pilot participants for final ratification. Data generated from trialling the questions through these consultations were not included in the main project.

Recruitment

Members of the VACMS Investigators' Group were asked to review the list of key informants prepared by Investigators. They were asked to suggest additional informants. However, members of the Investigators Group were not involved in contacting potential participants or conducting the research. The list of informants 'snowballed' through referrals during the fieldwork period.

Investigators aimed to recruit informants with knowledge of all datasets under study from across the academe, public health services and in government. There was a particular interest in the views of AHLOs.

Investigators sent an invitation to informants that included a plain language statement describing the research, questionnaire, draft Schema of Initiatives and a consent form (Appendix B).

In addition, investigators provided an overview of the study to attendees of the 2011 Victorian Aboriginal Community Controlled Health Organisation (VACCHO) State-wide ICAP Forum, where expressions of interest in participating were sought from AHLOs. An information sheet was also provided to AHLO supervisors at the Supervisors Network Meeting.

Sample

Of the 47 informants invited to participate, 35 accepted and one declined—the final number of participants was 34. Other invitees either did not respond to the invitation delegated the response to another staff member (included in the sample) or were unable to attend an interview. Five hospital Chief Executive Officers (CEOs) were invited to participate, but they either delegated the response to another health service manager or failed to respond.

Two informants spoke to investigators, but did not formally participate in the study or complete the questionnaire. These informal responses were incorporated into the discussion, but not the results of this study. A small number of invitees who participated in the study declined the invitation to be acknowledged by name in the final report.

The sample of informants was almost equally distributed between two types of informants. Table 4 (see next page) breaks down the sample into these two groups: policy/government and academic, and Aboriginal Liaison Officers (ALOs) and hospital-based staff. These two groups were defined by investigators during analysis of results. There was a very strong 'Aboriginal voice' in the sample, with approximately half the sample of informants identifying as Aboriginal.

The majority of the first group was made up of informants with experience in government and/or policy. Five academic-based informants were included in this group. The second group was predominantly made up of Aboriginal Liaison Officer personnel, including AHLOs and Koori maternity workers. This group included five informants in management or supervisory roles in health services.



Table 4: Distribution of sample by type of key informant (determined by investigators)

Type of Informants		Total
Policy/ government/ academic	ALO/hospital staff	
16 (49%)	18 (51%)	34 (100%)*

* Note: two policy/government informants elected to combine their responses into one questionnaire, therefore the final sample constituted 34 informants but 33 completed questionnaires.

Interviews

Informants were invited to meet with investigators for an estimated 30–60 minute interview to discuss and complete the questionnaire. Face-to-face semi-structured interviews were conducted with informants based on the semi-structured questionnaire (Appendix B). The interviewer delivered the questionnaire, and also asked for additional information to clarify answers given by the participant and to expand ideas. Informants were often asked to qualify their selection of options in tables in Questions 2.1, 2.2, 4 and 9 in cases where discussions had not resulted in a definitive (tick in a box) response.

In all but two instances, interviews were conducted at the informant's place of work. In one instance two informants asked to attend the university, and one interview was undertaken over the telephone to overcome issues of distance.

In the majority of interviews, two interviewers on separate questionnaires recorded the informant's remarks by hand. Several interviews were conducted with two informants and

two investigators. In most of these instances one investigator recorded the comments of one participant while the other recorded the comments of the second participant. In one instance, at the request of the participants, the comments of two participants were collated into one questionnaire.

As part of the interview, informants were asked to review the Schema of Initiatives. The questionnaire and Schema of Initiatives were provided to informants in advance of the meeting.

Following each interview, investigators collated notes into one electronic record and sent it back to the informant to review, make any amendments and confirm that the document accurately reflected the views and comments of the interviewee.

Annual variation in the number of Indigenous-identified births and hospitalisations

In addition to gathering the views of key informants, investigators wanted to explore whether any conclusions could be drawn regarding the efficacy of initiatives previously implemented to improve Indigenous identification. To achieve this, the initiatives were correlated with the number of Indigenous-identified births and hospitalisations recorded each year.

The annual number of Indigenous-identified hospitalisations was provided to the investigators by the custodian of the VAED, whereas birth data from the VPDC and RBDM were extracted from the DHS report *Koori Health Counts! 2006/07*.³⁷

³⁷ DHS 2008, *Koori Health Counts! 2006/07*, DHS, Melbourne.



Results

Findings and recommendations are the result of quantitative and qualitative analyses of key informants' views. Results from responses in tables in Questions 2.1, 2.2, 4 and 9 were summarised and graphed using Microsoft Word and Excel. Qualitative responses were transposed into separate Word files for each question and analysed (through thematic analysis) as textual and numeric data.

The 'Results' section includes the results of supplementary analysis comparing birth and hospitalisation data collected in the VAED, VPDC and RBDM and the timing of key initiatives implemented to improve Indigenous identification identified through interviews and the Schema of Initiatives.





Results

The results of this study include:

- a Schema of Initiatives/policies implemented to improve Indigenous identification in Victoria since 1980
- an analysis of responses to the questionnaire, including barriers/enablers and identification of initiatives, and recommendations for future engagement and policy regarding Indigenous identification
- an analysis of annual variations in the number of Indigenous-identified births and hospitalisations by dataset compared to the timing of key initiatives implemented to improve Indigenous identification.

This report also includes recommendations for achieving continued improvements in Indigenous identification in these datasets.

Final Schema of Initiatives

Appendix A provides a copy of the Schema of Initiatives developed by investigators from a literature review and incorporating participant input.

The Schema of Initiatives includes policies and initiatives likely to have had an impact on datasets as a whole. It excludes local initiatives specific to individual health services where the impact on the State-wide dataset is likely

to be minimal. Some of these local initiatives have been included in participant responses to Question 3 of the questionnaire regarding effective initiatives. For example, if an individual health service introduced Aboriginal artwork or raised the Aboriginal flag on significant days, or permanently in 2007, these activities have not been included in the Schema of Initiatives as they are unlikely to have had an impact on the number of Indigenous-identified patients in the VAED as a whole. However, they are listed in Appendix C, which summarises responses to Question 3.

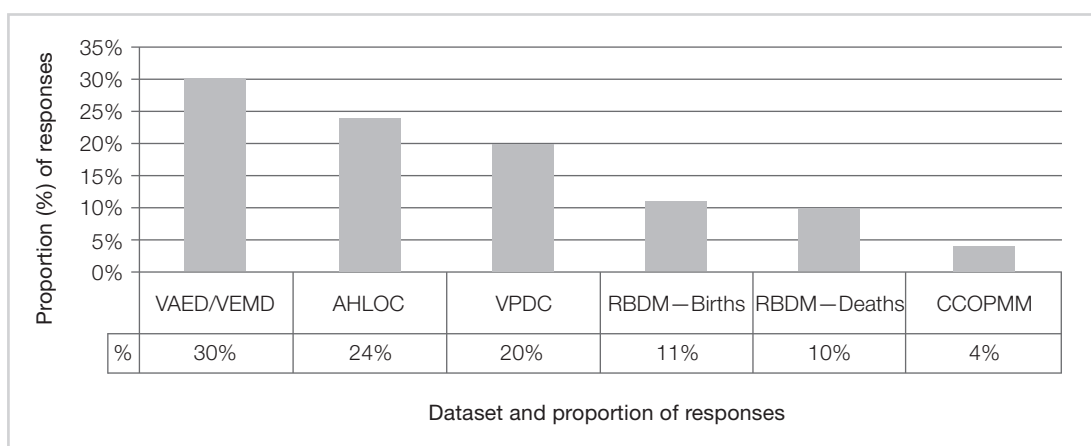
Responses to the questionnaire

Figure 2 (see next page) summarises responses to Question 1, which noted the specific dataset/s that informed an informants' knowledge of initiatives and/or policies implemented to improve Indigenous identification (note: informants could select more than one dataset).

Informants' knowledge was heavily weighted towards the hospital-based collections: 30% of all responses indicated knowledge of the VAED/Victorian Emergency Minimum Dataset (VEMD); 24% indicated knowledge of the AHLOC and 20% indicated knowledge of the VPDC. There was less knowledge in the sample about initiatives associated with the RBDM (births) (11%), RBDM (deaths) (10%) and CCOPMM (4%) datasets.



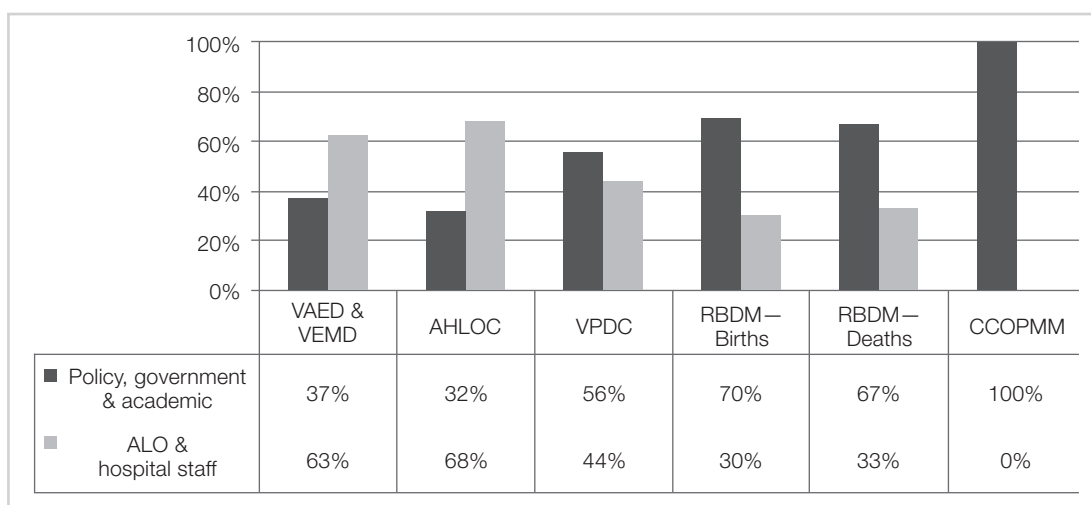
Figure 2: Distribution of responses to Question 1 relating to the specific dataset/s that informed an informants' knowledge of initiatives and/or policies implemented to improve Indigenous identification



The policy/government/academic group contributed a greater proportion of knowledge relating to the VPDC, RBDM and CCOPMM datasets than the ALO/hospital staff. Conversely, the ALO/hospital staff group contributed a greater proportion of the

knowledge relating to the hospital-based collections, the VAED, VEMD and AHLOC. However, a sizable contribution of knowledge of these datasets was also provided by the policy/government/academic group (see Figure 3 below).

Figure 3: Proportion of informants with knowledge of initiatives and policy relating to Indigenous identification by informant type and dataset



Note: informants could nominate more than one dataset.



Topic 1: Barriers to Indigenous identification

Questions 2.1 and 2.2 interrogated key informants' views on barriers to accurate identification of Indigenous status in their professional and personal experience.

Question 2.1

Respondents were asked to review a series of previously published barriers to Indigenous

identification and to rate how valid they believed they were to improving Indigenous identification, based on their professional experiences. Note: the term 'validity' in Question 2.1 is not used as the statistical term but, rather, was used in the question asked of informants.

Table 5 (below) summarises responses to the question of validity as a proportion of all responses.

Table 5: The validity of previously reported barriers to Indigenous identification as rated by all key informants (number and proportion of all responses by barrier)

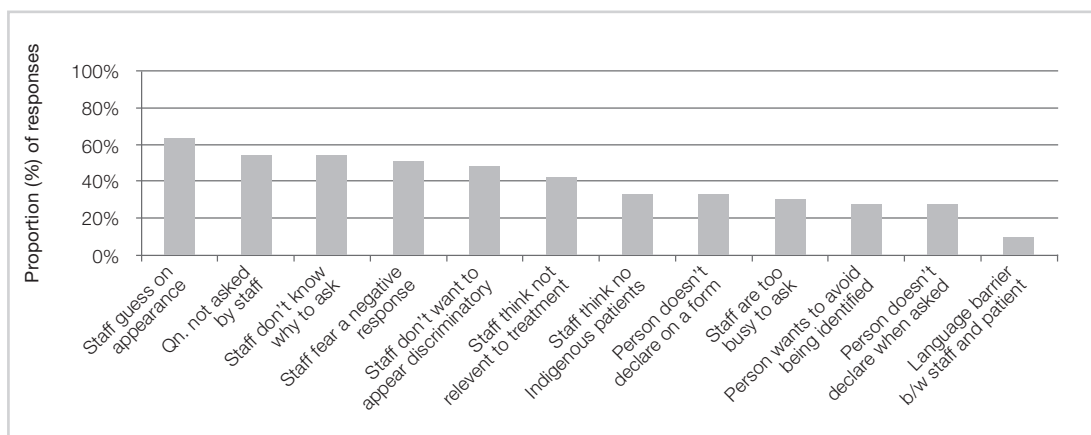
Previously published barriers to Indigenous identification	Validity					Total responses
	Not valid	Low validity	Med. Validity	High validity	N/A	
Indigenous question is not asked by staff at registration	<5 (6.1%)	<5 (3.0%)	11 (33.3%)	18 (54.5%)	<5 (3.0%)	33 (100%)
Staff member doesn't know why the question should be asked	<5 (3.0%)	9 (27.3%)	<5 (12.1%)	18 (54.5%)	<5 (3.0%)	33 (100%)
Staff member doesn't want to appear discriminatory	<5 (3.0%)	<5 (9.1%)	12 (36.4%)	16 (48.5%)	<5 (3.0%)	33 (100%)
Staff member feels the question is irrelevant to treatment of the patient	<5 (9.1%)	6 (18.2%)	8 (24.2%)	14 (42.4%)	<5 (6.1%)	33 (100%)
Staff member feels the question isn't relevant (e.g. they don't have any Indigenous patients)	<5 (9.1%)	7 (21.2%)	10 (30.3%)	11 (33.3%)	<5 (6.1%)	33 (100%)
Staff member fears a negative response to the question	<5 (9.1%)	<5 (6.1%)	8 (24.2%)	17 (51.5%)	<5 (9.1%)	33 (100%)
Staff member is too busy to ask all questions at registration	7 (21.2%)	8 (24.2%)	6 (18.2%)	10 (30.3%)	<5 (6.1%)	33 (100%)
Staff member guesses Indigenous identity based on appearance	<5 (9.1%)	<5 (12.1%)	<5 (12.1%)	21 (63.6%)	<5 (3.0%)	33 (100%)
Indigenous person chooses not to declare their status on a form (e.g. birth/death registration form)	<5 (3.0%)	10 (30.3%)	6 (18.2%)	11 (33.3%)	5 (15.2%)	33 (100%)
Indigenous patient chooses not to declare their status in response to the question asked	<5 (6.1%)	7 (21.2%)	10 (30.3%)	9 (27.3%)	5 (15.2%)	33 (100%)
The Indigenous patient wishes to avoid being identified in the hospital	<5 (9.1%)	6 (18.2%)	8 (24.2%)	9 (27.3%)	7 (21.2%)	33 (100%)
A language barrier exists between staff and patient	6 (18.2%)	17 (51.5%)	5 (15.2%)	<5 (9.1%)	<5 (6.1%)	33 (100%)



Figure 4 (below) shows the proportion of informants rating previously reported barriers to Indigenous identification as having high validity. 'Staff member guesses Indigenous identity based on appearance' was rated as the most relevant barrier by the largest number of informants (63.6%), followed equally by 'Indigenous question is not asked by staff at registration' (54.5%) and 'staff

member doesn't know why the question should be asked' (54.5%). The barriers to identification with the lowest proportion of informants rating them of high validity were a 'language barrier exists between staff and patient' (9.1%), 'person doesn't declare when asked' (27.3%) and 'person wants to avoid being identified ' (27.3%).

Figure 4: Proportion of informants rating previously reported barriers to Indigenous identification of high validity, sorted in descending order



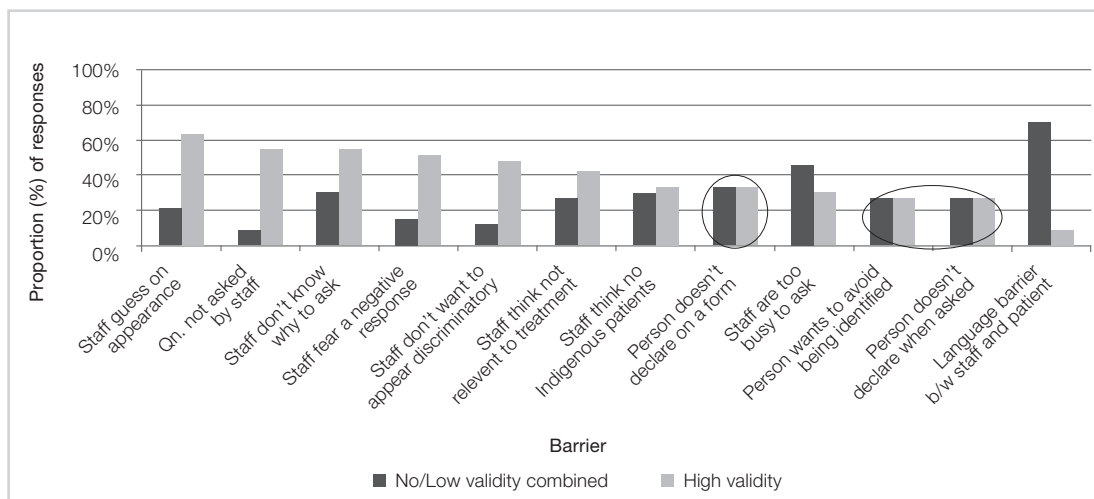
At the other end of the spectrum, the barrier with the largest proportion of informants rating it of low or no validity was a 'language barrier exists between staff and patient' (69.7%), followed by 'staff are too busy to ask' (45.4%) and 'person doesn't declare on a form' (33.3%). Only 9.1% of informants believed the 'question is not asked by staff' was of low or no validity.

Informants' views on the validity of barriers were not quite inversely related at the two extremes. Figure 5 (see next page) shows that some barriers were rated equally of low/

no validity and high validity (circled), indicating some contention within the group. This was the case for barriers relating to disclosure of status such as 'person doesn't declare on a form', 'person wants to avoid being identified' and 'person doesn't declare when asked'. Although informants were in relative agreement that barriers relating to the question being asked by staff are highly valid, there was less agreement relating to the validity of barriers relating to patients/clients declaring their status.



Figure 5: Proportion of informants rating previously reported barriers to Indigenous identification of high validity, and of no or low validity combined



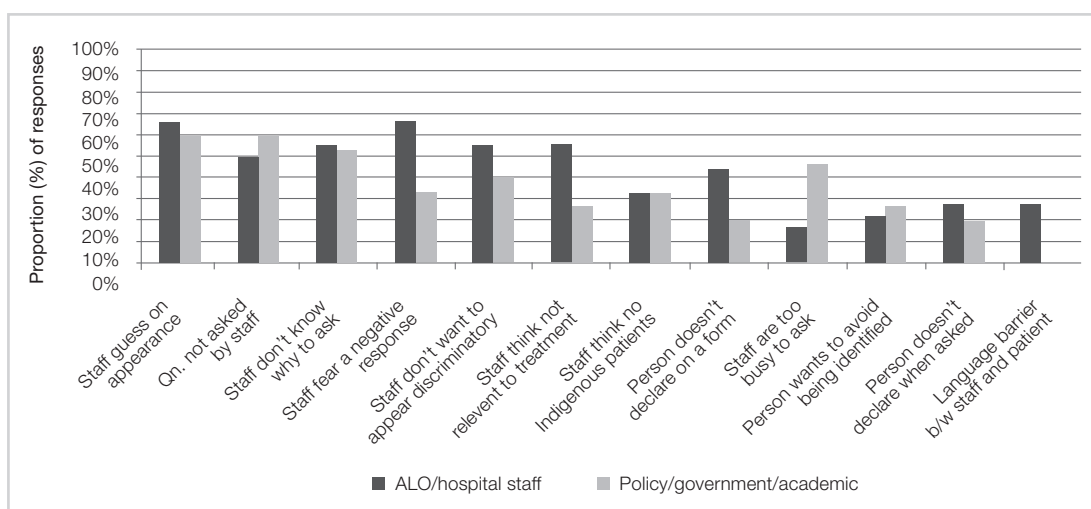
When responses to the question were disaggregated by the two groups of informants (see Figure 6 on next page), there was good agreement that 'staff guess identity on appearance', 'staff don't know why to ask' and 'question not asked by staff' were highly valid barriers to identification. A greater proportion of the ALO/hospital staff group believed that the questions 'staff fear a negative response', 'staff don't want to appear discriminatory', 'staff think not relevant to treatment' and 'person doesn't declare on a form' were highly valid barriers.

Few hospital staff believed that 'staff are too busy to ask' was a highly valid barrier to identification (16.7%), whereas almost half of the policy/government/academic group of informants thought it was a highly valid barrier (46.7%).

Comments provided by informants in the ALO/hospital staff group relating to the validity of a 'language barrier between staff and patient' related more to a communication barrier than to a difference in the language spoken (see comments with Figure 18).



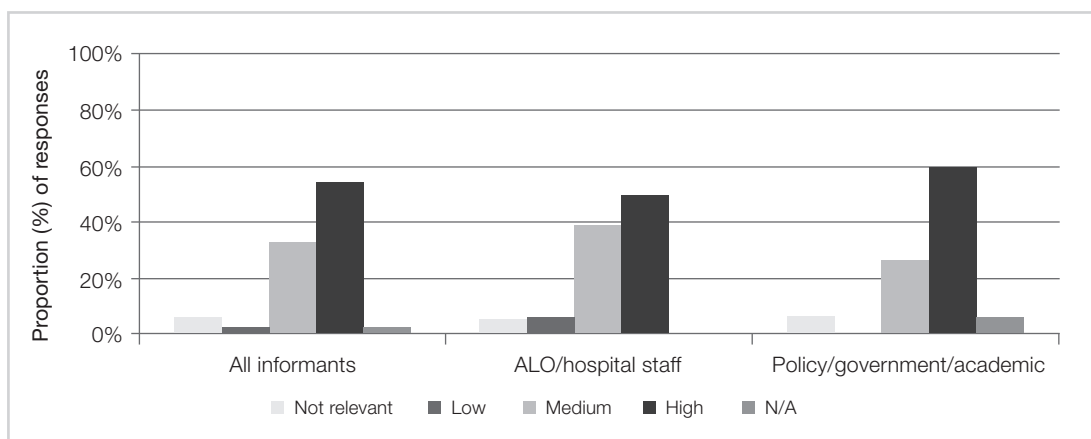
Figure 6: Proportion of informants in the policy/government/academic and ALO/hospital staff groups rating previously reported barriers to Indigenous identification of high validity



Figures 7–18 summarise the distribution of responses to each barrier for the sample as a whole and disaggregated by informant group. Each item is accompanied by a selection

of comments provided by informants. All comments for each barrier are provided in Appendix C. Figure 7 (below) reports responses to 'Question is not asked by staff'.

Figure 7: 'Question is not asked by staff'



More than 50% of informants, both combined and disaggregated by informant group, rated the barrier 'staff member doesn't know why the question should be asked' of high validity, while more than 20% of informants rated the barrier of low relevance (see Figure 8 below). Many of the comments provided by informants specified that staff 'should' know why the question of Indigenous status needs to be asked and therefore this barrier should be of low validity.

Informant comments (direct quotes):

Most staff at this hospital have attended training so they should know why.

Mainstream funeral directors are unlikely to know why the question should be asked.

Feedback from funeral directors has supported this assumption.

In a mainstream setting I can only focus on the details of the program and how identification is important for quality of care. Staff need a deeper cultural understanding of the importance of data to closing the gap and cultural safety in a mainstream setting.

Staff are still not educated to know why they are asking the question. Services should have roles/staff to engage with the community to reduce the fear of a negative response and reinforce that the health service does have Aboriginal patients.

Uncertainty whose responsibility it is to ask the question (e.g. General Practitioner or receptionist).

Figure 8: 'Staff member doesn't know why the question should be asked'

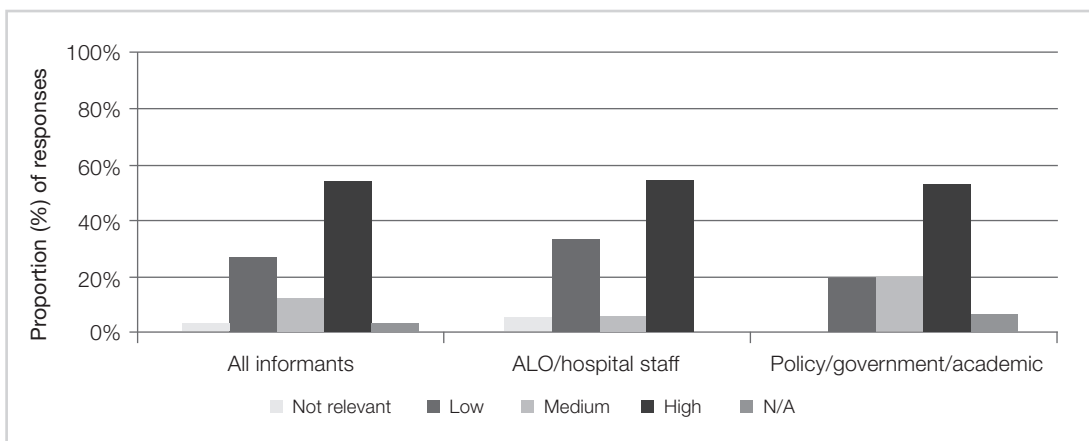
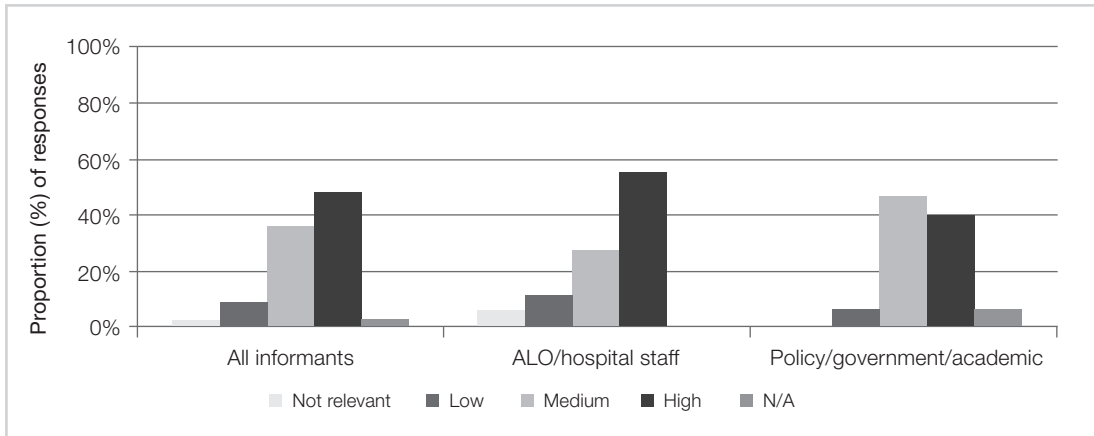


Figure 9: 'Staff member doesn't want to appear discriminatory'



The barrier 'staff member doesn't want to appear discriminatory' was rated of medium or high validity consistently in the sample and across informant groups (see Figure 9 above).

Front line staff can be concerned about appearing discriminatory and offensive, particularly if they are unsure why the question needs to be asked, they can't make the connection with care provided later.

Informant comments (direct quotes):

Staff members can actually experience a backlash from patients.

I have heard this from staff quite often.

Some people believed it was racist to ask.

People don't know the question is mandatory and has been since 1993, all staff should know it (e.g. nurses, social work etc).

Figure 10: 'Staff member feels the question is irrelevant to treatment of the patient'

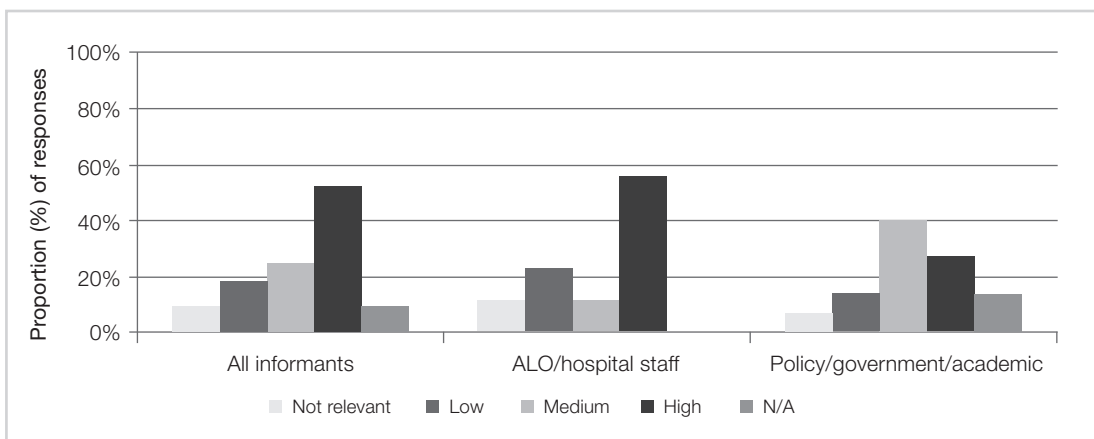


Figure 10 (see previous page) identifies that less than half of all informants rated the barrier 'staff member feels the question is irrelevant to treatment of the patient' of high validity, while the rest rated the barrier as medium (24.2%), low (18.2%) and not valid (9.1%). The policy/government/academic group was less likely to consider that the question was not relevant to the treatment of patients was a 'high' barrier compared with the ALO/hospital staff group (56% to 23%). There was also a broader spread of responses, and therefore agreement, among the policy/government/academic group.

Informant comments (direct quotes):

Perhaps until the reasoning is explained. Staff may wonder why they ask this question and not questions about other ethnicities.

Most staff don't understand the link between identification and the provision of services and treatment. A lot of staff are shift workers so it's not their fault that they are unaware of the link.

This is why we have ongoing competency training.

Funeral directors know the question is relevant.

Figure 11: 'Staff member feels the question isn't relevant (e.g. they don't have any Indigenous patients)'

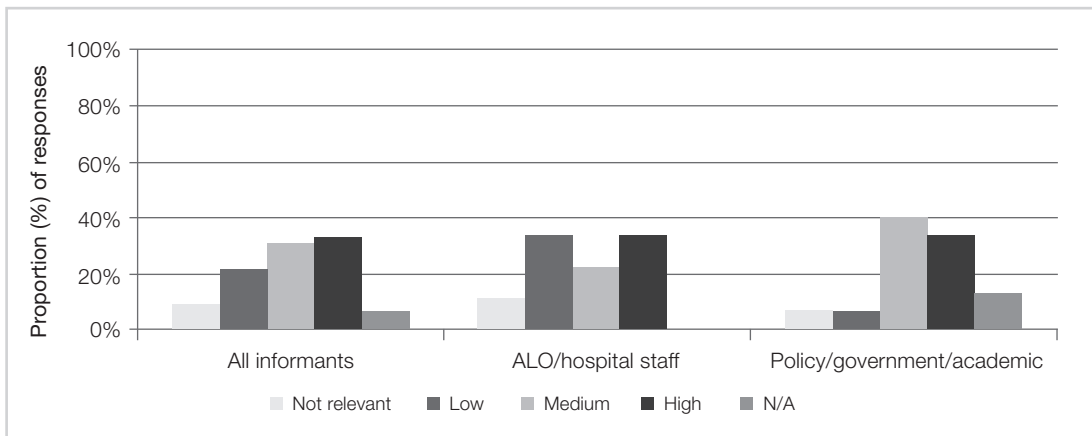


Figure 11 (above) shows that responses to the question of validity associated with the barrier 'staff member feels the question isn't relevant' varied according to an informant's role and the status of Aboriginal programs and knowledge of identification and training at the informant's health service/organisation. There were a few N/A responses from policy personnel who were either not familiar with hospital datasets and/or not closely associated with hospital operations.

Informant comments (direct quotes):

Varies for staff depending on location of the hospital and if they believe they have a local Aboriginal community.

There may be some confusion with funeral directors that the Aboriginal Funeral Service coordinates all Aboriginal funerals, when in fact it doesn't. This may be a barrier to asking the question.

There is a belief that Aboriginal and Torres Strait Islander patients don't attend private hospitals.

This is likely to be the biggest barrier in Victoria (e.g. Some General Practitioners believe there are no Aboriginal people in Victoria).

Most staff at this hospital know we have a lot of Indigenous patients, whereas agency staff may be less aware.

There was general agreement that the fear of a negative response to the Indigenous status question was of medium to high validity as a barrier to Indigenous identification (see Figure 12 below). However, there was double the proportion of ALO/hospital staff informants rating it of high validity than policy/government/academic informants. More than 50% of the latter rated the barrier of medium validity.

Informant comments (direct quotes):

This is likely to be a significant barrier in Vic.

Health and safety issue—some may not ask in the Emergency Dept to avoid putting themselves at risk.

Staff don't want to offend. They may be more fearful when asking a seemingly non-Aboriginal person.

Staff training should result in staff consistently asking the question and responding when patients ask why the question is asked.

Question is not asked, therefore they aren't fearing a negative response.

Figure 12: 'Staff member fears a negative response to the question'

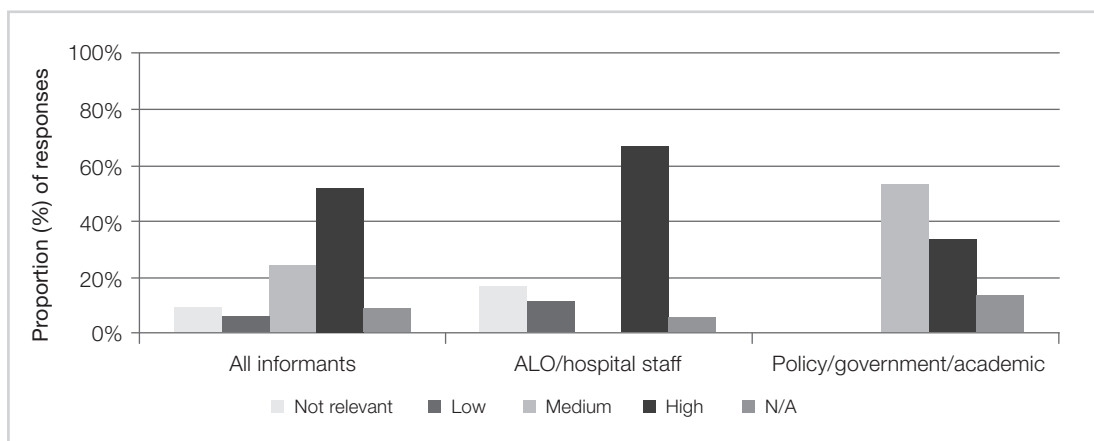
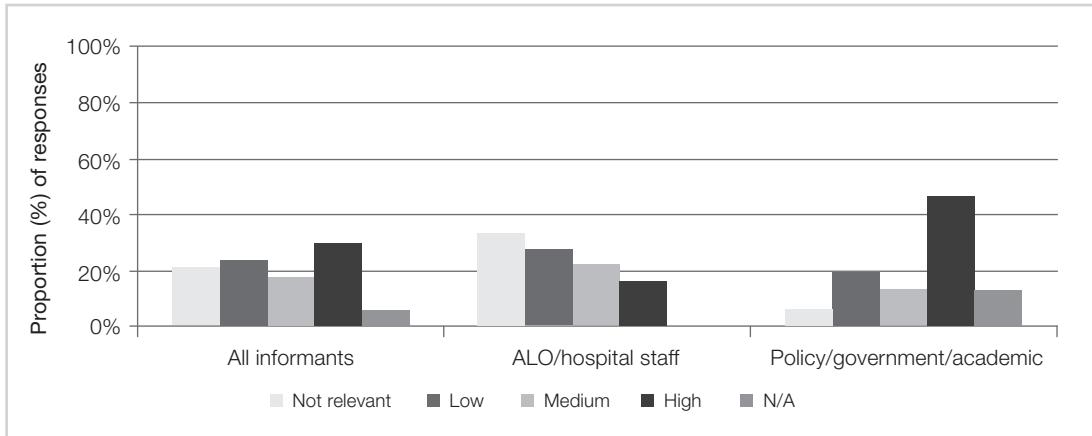


Figure 13: 'Staff member is too busy to ask all questions at registration'



Although a greater proportion of the policy/government/academic informant group rated the barrier 'staff member is too busy to ask all questions at registration' of higher validity than the ALO/hospital staff group, the diversity of views was supported by a wide variation in responses across the sample and within each informant group (see Figure 13 above). This diversity was also reflected in informants' comments (direct quotes):

Being too busy to ask is not an excuse. Most staff ensure other questions are asked at registration so clearly there are other

barriers that come into play when it comes to asking 'the question'.

Staff are busy but not too busy. If they are unsure why the question must be asked, they are likely to skip it.

This may be an issue in the Emergency Department.

Not sure first hand if this is a barrier but it's possible. If staff ask the identity question they also need to ask the next question about linking with services like the AHLO.

BDM [Births, Deaths and Marriages] generally doesn't meet the person.

Figure 14: 'Staff member guesses Indigenous identity based on appearance'

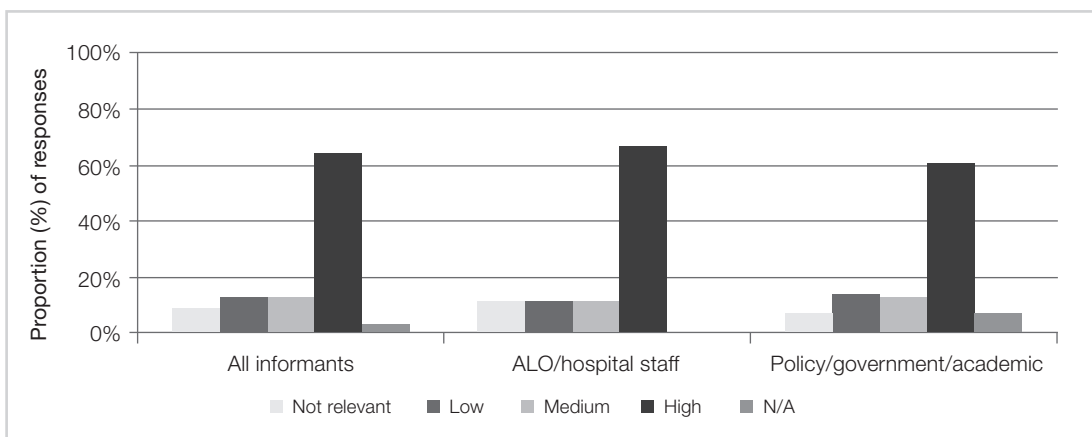


Figure 14 (see previous page) shows that there was general agreement between respondents that the barrier 'staff member guesses Indigenous identity based on appearance' was of high validity. The proportion of respondents rating this barrier of high importance was greater than 60% in the whole group and when disaggregated into two groups.

Informant comments (direct quotes):

Staff may have the perception that Indigenous people are supposed to look a certain way.

Some staff still have the perception that they can tell based on appearance.

This happens—we have seen Indian and Sri Lankan patients identified as Aboriginal.

There are examples of Aboriginal-identified birth and death registrations where the surname raises suspicion that the individual may be of a foreign origin. These are checked by BDM staff.

Perhaps prior to Indigenous workshops [a staff member might guess Indigenous identity based on a person's appearance].

Figure 15: 'Indigenous person chooses not to declare their status on a form'

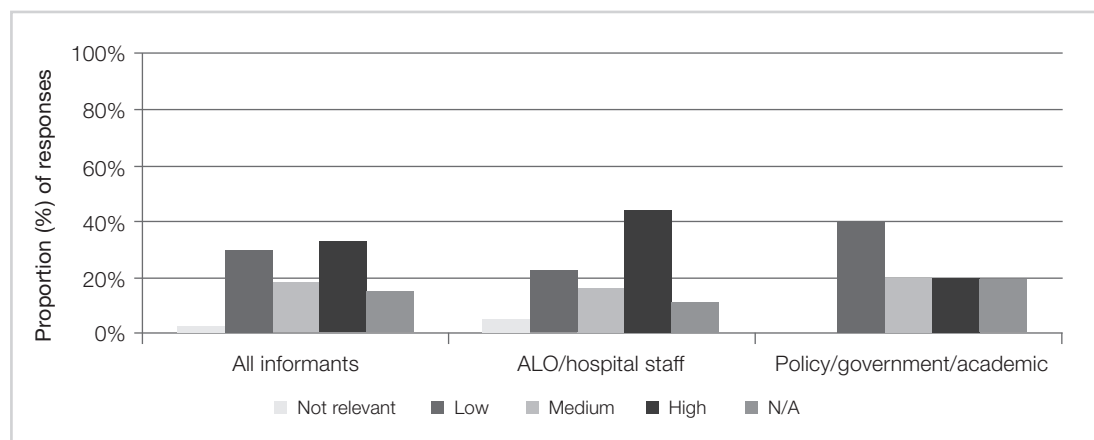


Figure 15 (above) identifies that responses varied to the barrier 'Indigenous person chooses not to declare their status on a form'. The largest proportion of informants from the ALO/hospital staff group rated this barrier of high validity (44%), while the largest proportion of the policy/government/academic group rated it of low validity (40%). Comments related to issues of literacy, perceived stigma/benefit to the patient, and the outcome of an Indigenous person's previous contact with government services and health services.

Informant comments (direct quotes):

Patient may feel overwhelmed filling out a form or may have difficulty reading it—forms are rarely fully completed.

A persons' declaration of their Indigenous status on a form is dependent on a combination of stigma and perceived benefit.

I haven't seen an Indigenous patient not identify but it would depend on someone's background and experiences. Some factors might include if they were removed as a



child or adopted, or if they wish to connect with the community (referrals to 'link up' happen often at this hospital to support people establish their identity).

Indigenous people are proud to say they are Aboriginal in this health service because the community is solid here.

Often Indigenous patients don't want to be targeted or treated differently.

Some choose not to identify particularly if they don't want to see the AHLO. Accurate data, sometimes non-Indigenous identifying takes place.

Fewer informants in the ALO/hospital staff group rated 'Indigenous person chooses not to declare their status in response to the question asked' of high validity than 'Indigenous person chooses not to declare their status on a form' (see Figure 16 below). Many of the informants commented that willingness to self-identify depended on the setting, environment and the way the question was asked.

Informant comments (direct quotes):

Identification rates are likely to be higher if asked face-to-face rather than on a form. Although this depends on how the question is asked and the situation.

Identification changes depending on whether a person is willing to declare their status at the time or not; influenced by whether the patient feels culturally safe/unsafe.

There is a quicker and more accurate response if the question is asked face to face.

Response if question is asked may be 'Why do you want to know?' There is still a fear of welfare stigma, that someone will come and look at their home or take their baby away.

A non-Aboriginal mother may elect not to identify the father as Aboriginal when asked, but might feel comfortable reporting his Aboriginality on a form.

Figure 16: 'Indigenous person chooses not to declare their status in response to the question asked'

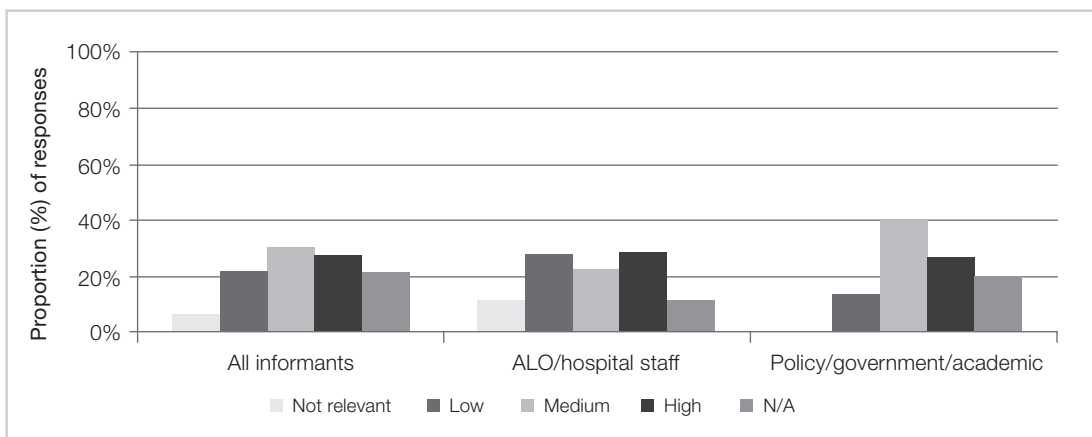
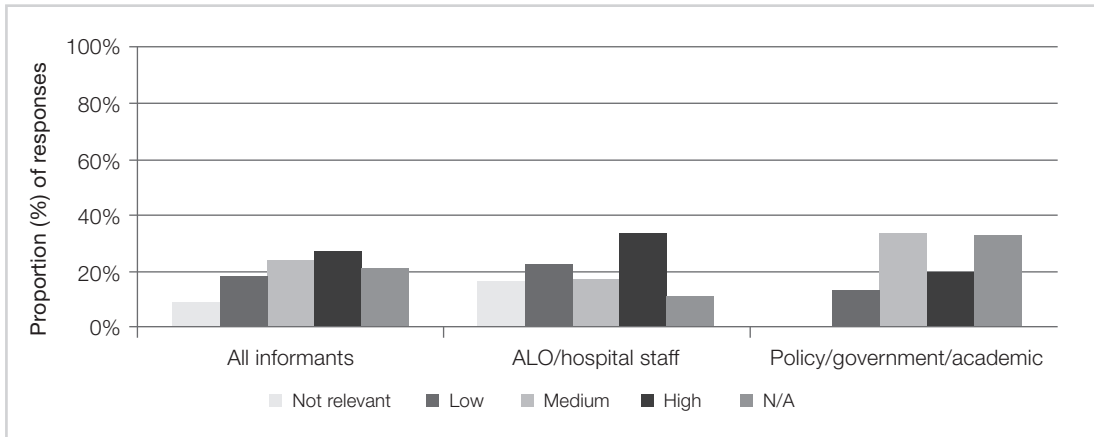


Figure 17: 'The Indigenous patient wishes to avoid being identified in the hospital'



Responses varied to the barrier 'the Indigenous patient wishes to avoid being identified in the hospital' (see Figure 17 above). Most comments related to the patient's relationship with the AHLO and a desire to have contact with the AHLO during admission. This raised suggestions for more AHLOs to be employed in each health service to provide a greater opportunity for patients to engage with AHLOs, therefore potentially increasing their willingness to identify.

Perhaps to avoid the AHLO and/or avoid discrimination if perceived not to appear Aboriginal.

We [AHLOs] will never know if there are people that want to avoid being identified.

Need for more than one AHLO funded position so that the patient has choice in who they see. A male patient may choose not to identify if they know the AHLO is female.

Informant comments (direct quotes):

Potentially dependent on the cause of admission.

Sometimes it can happen, especially if the question is asked while the patient is in a queue around other patients.

Figure 18: 'A language barrier exists between staff and patient'

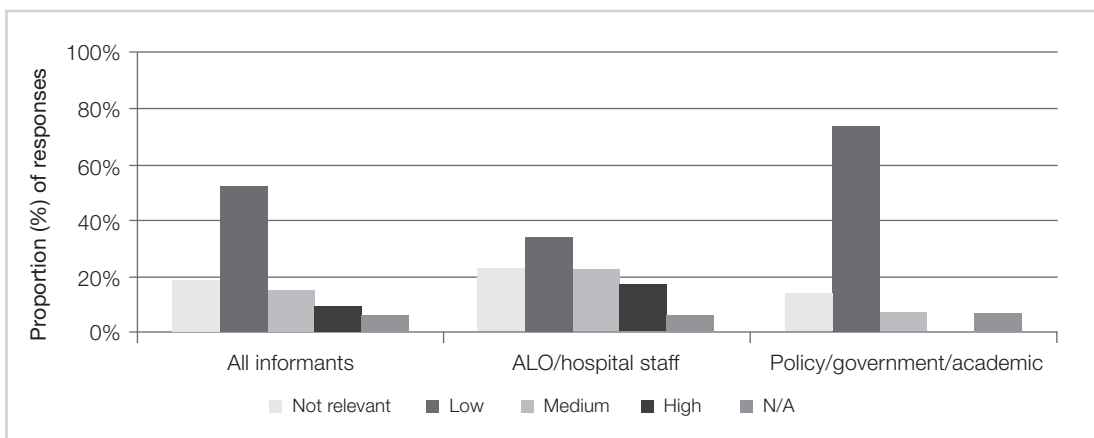


Figure 18 (see previous page) reports that informants strongly agreed that ‘a language barrier exists between staff and patients’, but was of low validity. Comments from many of the AHLO informants talked about language in terms of literacy and numeracy and communication rather than the English language versus traditional Aboriginal languages. Most respondents also acknowledged that some hospitals received interstate patients who were more likely to experience issues with the English language. Also of relevance was the language barrier that resulted when hospital clerks had a thick foreign accent.

Informant comments (direct quotes):

Language could act as a barrier if the patient doesn't understand what is being asked (e.g. they don't understand what the Registrar is asking, potentially because they have a foreign accent).

Language may be a barrier between patients and international health graduates working in this health service, but it is unlikely to impact on identification.

Therefore, orientation sessions are carried out to try and eliminate any language barrier e.g. what does it mean when a patient responds with the word 'deadly'?

This is less relevant. If a person is coming from a remote community, it is known that they are Indigenous anyway.

Language may be a barrier depending on the client's level of education.

Not in the sense of not speaking English as a first language but definitely in a communication sense. Language is more than just words. The hospital environment can be intimidating and the way staff communicate with patients can 'be scary'. A patient may make a decision whether to identify based on the way they were asked or how scary the staff member registering them was.

Figure 19 (below) summarises informant responses to the validity of three barriers: the ‘Indigenous question is not asked by staff’ and the ‘Indigenous patient chooses not to identify when asked by staff’ or ‘when asked on a form’.

The question not being asked by staff rated more highly than people choosing not to declare their status on a form or when asked.

Figure 19: Comparison of all responses rating the validity of three barriers to identification: the Indigenous status question not being asked by staff and Indigenous patients choosing not to identify on a form or when asked

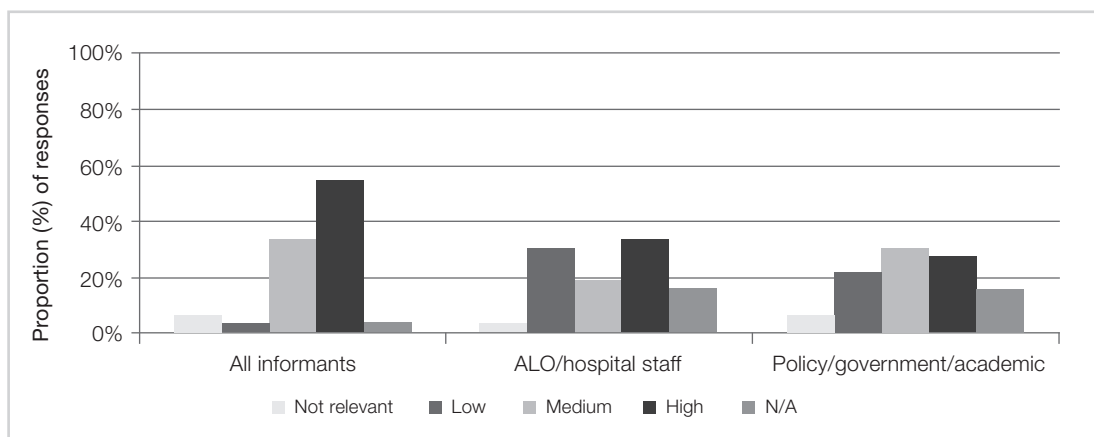


Figure 19 (previous page) also indicates that informants were also asked if there were any other notable barriers to identification not listed in the table in Question 2.1. Thematic analysis of comments resulted in three main themes. Selected comments provided by informants are summarised into these themes in Table 6 (below) (all responses are listed in Appendix C).

The three themes are:

- Theme 1—Issues relating to the question being asked and attitudes of staff
- Theme 2—Issues relating to disclosure of status, e.g. fear of stigma and government interference, distrust, unknown identity and illiteracy
- Theme 3—Presence or lack of an AHLO or Aboriginal staff member/s.

Table 6: Examples of ‘other’ barriers to Indigenous identification mentioned by key informants

Theme 1: Issues relating to the question being asked and attitudes of staff
Staff member doesn't know how the question should be asked.
There may be a cultural barrier to understanding why it's important to identify Aboriginal patients. Staff require an in-depth understanding of the 'case work' that can follow identification. They don't go home to the community and share their experiences.
Staff member thinks they already know the answer from a previous admission.
The question should be asked at every episode as a patient's willingness to identify changes. For example, a person may be proud at the time of one admission and then following a falling out in the community, they may wish not to identify the next time if asked.
Staff member knows the person, therefore feels there's no need to ask.
Staff may feel uncomfortable asking the Indigenous question of someone whose appearance clearly reflects another nationality.
In the Maternity Ward, staff assume the baby/father aren't Indigenous if the mother isn't.
Staff member is not confident explaining why the question is asked.
Asking the question on the phone is easier than asking it face-to-face. Some staff feel more confident asking it via phone.
Clerical staff may fear abuse from non-Aboriginal patients.
Rollover of staff: Agency staff don't bother asking the question.
Staff don't want to offend non-Aboriginal people.
Staff have commented 'why do Aboriginal patients get special treatment?' a view which prevents some staff from asking.
When someone dies there's not a lot of care taken filling out death certificates, that's why we don't get good data.
Not recording father's status in the Perinatal collection prior to 2009—Aboriginal Hospital Liaison Officers tasked for this change.



Theme 2: Issues relating to disclosure of status

Hesitation registering a death due to fear that social services will be cut off.

Distrust between the Aboriginal community and government agencies.

A mother might fear her information will end up with DHS; that her information will not be kept private.

Different experiences of treatment received at other organisations (e.g. Centrelink).

Indigenous person chooses to identify in different settings (e.g. financial incentives).

A person may choose to identify/not be identified at different stages of their lives.

A pregnant woman may choose not to identify the father due to pressure from her family members—Aboriginal fathers may be less inclined to be involved in the birth.

A person may not always be aware they are Indigenous (especially if a member of the Stolen Generations).

The Indigenous patient chooses not to declare their status due to fear of being treated differently to other patients.

Indigenous patient's willingness to declare their status is dependent on how safe they feel declaring it. The organisation needs to be culturally safe and the individual needs cultural ease (e.g. 'I can be myself here').

The 'self-identification' criteria is an issue—non-Aboriginal patients sometimes identify.

They may fear a negative response from staff, which they would get offended by.

An Aboriginal patient might leave the [Emergency Department] after a long wait and having watched other patients 'go through' concluding that the staff are racist at that hospital. This may add to a belief that they're being discriminated against and may prevent them from identifying in the future.

Literacy is a barrier when filling in a form.

Theme 3: Presence or lack of an AHLO or Aboriginal staff member/s

The absence of an AHLO in a hospital may act as a barrier.

Staff not informing patients of the presence of Aboriginal workers in the organisation may act as a barrier to identification.

The resignation of an Aboriginal staff member might impact on numbers.

An Indigenous person may choose not to declare their status if they dislike the AHLO, or there are gender differences between the patient and AHLO.

There needs to be a way to separate identification from contact with the AHLO so that the patient can choose to identify and also choose not to have contact with the AHLO if they don't want it.

Confidentiality policies in the workplace can act as a barrier as AHLOs aren't allowed to see a patient without invitation. If an AHLO [breaches] this they are at risk of disciplinary action for [breaching] policy.



Question 2.2

Informants were asked to indicate whether they, either as a health services' user or a registrant of a birth or death, had been asked and/or had elected to identify their Indigenous status. The results in row 2.2.1 of Table 7 (below) reflect those provided in response to Question 2.1 regarding the validity of the

question not being asked by staff as a barrier to identification.

In row 2.2.1, 30% of respondents indicated that they had never been asked the question of Indigenous identification and 55% indicated that they had been asked sometimes, while only 9% indicated they had always been asked.

Table 7: Summary of responses to Question 2.2 relating to personal experiences of identification when accessing a health service or registering a birth or death

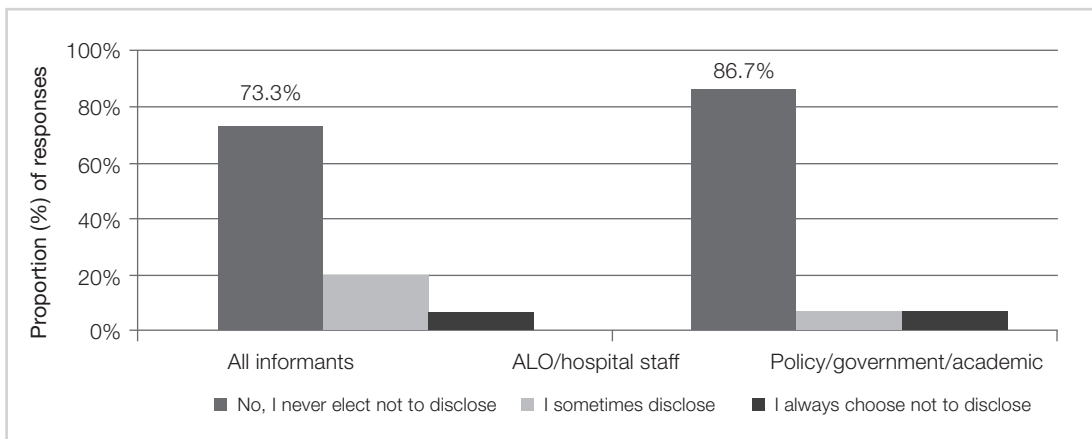
Question	Don't know/ can't recall	No, never	Sometimes	Yes, always	N/A	Elect not to answer	Total responses
2.2.1 The Indigenous identification question is not asked by staff		10 (30.3%)	18 (54.5%)	3 (9.1%)	2 (6.1%)		33 (100%)
2.2.2 I choose not to declare my Indigenous identification when asked (if applicable)		11 (33%)	3 (9%)	1 (3%)	15 (46%)	3 (9%)	33 (100%)
2.2.3 I choose not to identify my Indigenous identification on a birth/death registration form (if applicable)		13 (39%)	1 (3%)	1 (3%)	15 (46%)	3 (9%)	33 (100%)

The results in Figure 20 (see next page) are based on the 15 informants who answered Questions 2.2.2 and 2.2.3 and exclude the informants who selected N/A or elected not to answer the question. For the most part, these informants were non-Indigenous and therefore the question was not applicable.

Figure 20 indicates that of the 15 informants who provided a response to Questions 2.2.2 and 2.2.3, 73.3% never withheld their Indigenous identity when asked, and 86.7% never withheld their Indigenous identity when filling in a form.



Figure 20: Summary of responses relating to an informant's propensity to identify Indigenous status when accessing a health service or registering a birth/death



Furthermore, comments accompanying responses relating to self-disclosure indicated that Aboriginal informants were very proud of their Aboriginal identity and were willing to identify when given the opportunity to do so.

Comments included (direct quotes):

I am very proud—I am happy to identify.

I am proud of who I am and my cultural beliefs so I would definitely identify.

I always declare, I am proud of who I am. In the past Indigenous people may have hidden their Indigenous status in order to protect their families, due to past unsafe practices.

Informants were also asked to suggest additional personal barriers to identification. These are listed in Table 8 (below).

Table 8: Examples of other barriers to Indigenous identification reflecting informants' personal experience (direct quotes)

Examples of other barriers to Indigenous identification mentioned by informants in their personal experience

Not being asked the question was a barrier to answering 'no' in my case and my [children's].

There were no posters at admission. Unless you were feeling very strong minded about identifying, the opportunity to say yes or no wasn't there.

Doctors and nurses judging and making assumptions [based on my appearance].

Not being asked/identified at the first hospitalisation, then not being asked at a later stage.

Being worried about how the staff would judge me and question my Aboriginality based on my appearance. For example, [they might] question 'how much' Aboriginal I am.

Topic 2: Initiatives and policies implemented to improve Indigenous identification

Question 3

Informants were asked to review the Schema of Initiatives developed by investigators as part of the literature review and to suggest initiatives or policies that they believed were missing from the Schema. All responses were recorded in the participant's questionnaire. However, only those initiatives that investigators believed were likely to have impacted on a dataset as a whole were added to the Schema (see final Schema in Appendix A).

Local initiatives implemented in individual hospitals were unlikely to have had an impact on the VAED and VPDC State-wide data so were excluded from the Schema. Thematic analysis of these initiatives resulted in four main themes. In Table 9 (below) responses are listed under the headings:

- Theme 1: Education and support materials
- Theme 2: Partnerships
- Theme 3: Validation and quality assurance
- Theme 4: Cultural acknowledgment and safety.

Table 9: Local initiatives mentioned by key informants (not included in the Schema) (direct quotes)

Theme 1: Education and support materials

Training of registration staff provided by and in this hospital.

Educating international medical/nursing graduates [in the hospital], helping them understand Aboriginal culture and language/phrases.

Staff orientation: the AHLO delivers a half hour PowerPoint presentation on the ICAP Program and Liaison services. This presentation doesn't go into detail about the bigger picture regarding health, wellbeing and identification.

Half-hour education programs initiated and conducted by the hospital for 30 minutes, four times a year. All staff expected to attend from Environmental Services throughout.

Separate cross-cultural training workshops.

Hospital-run identification workshops are an opportunity for staff to share their past experiences and hear other peoples' perspectives. We instruct staff to never assume a patient's identity. Staff are given the opportunity to ask the AHLO questions after the session.

Working with Aboriginal patients' training for hospital staff.

This consists of a 15min introductory talk with a 45min optional extended program. The session is delivered by me, the AHLO, on request, but twice a year management send out a letter requesting departments undertake the training and this is offered to all departments.

In this talk, I discuss what my life has been like as an Aboriginal woman and what my mother and my grandmother's experiences have been so that staff can understand why patients are the way they are, and be aware the issues are current and not in the past as most think. I talk about identity and why I see myself as Aboriginal rather than non-Aboriginal. I explain how demeaning it is to have your culture questioned ('you're only a little bit Aboriginal') and how culture is rarely questioned of people of other cultures.

Feedback from staff has been very positive and the number of identified patients tripled after we monitored sessions at a site. There was a bigger response from nurses than clerks. Some nurses commented that they didn't understand, and following the training they did. Nurses were able to identify Aboriginal patients on the ward after they had been incorrectly identified at admission. Twelve nurses went on to work in remote communities.

AHLOs provide regular training to capture all staff of the hospital due to quick changeover of staff.



The AHLO's role is highlighted in orientation sessions to all staff.

Staff from each department of the hospital goes through cultural training to encourage staff to make Aboriginal health their business as well.

2008: Cultural awareness seminars provided throughout the hospital and Medical School by Wathaurong Aboriginal Cooperative.

Aboriginal Associates Program was introduced to provide specific cultural training to staff in all areas of the hospital. These staff members receive a badge to encourage other staff members to ask questions of them if in doubt (AHLOs can't cover the whole hospital at all times).

Partnership with the co op midwife where she will undertake our training so she can be the 'midwife' for low risk pregnancy instead of at the hospital.

Patient care books include information on the AHLO/services, and an insert is included for the trainee doctors.

Quality of care sessions/materials: Articles are prepared throughout the year to raise awareness of Indigenous health outcomes and the importance of providing quality care.

Cue cards for registration staff consisting of suggested responses to potential negative responses to the question being asked.

Theme 2: Partnerships

The local partnership agreement between the health service and Aboriginal Community Controlled Health Organisation is underpinned by an annual action plan annual priorities. There is a taskforce comprising of the ACCHO [Aboriginal Community Controlled Health Organisation] board and senior health service staff.

Partnership with the coop whereby the midwife at the co-op can provide antenatal care and accompany the woman to appointments at the hospital. This has resulted in greater identification of expecting mothers as hospital staff are now familiar with the Aboriginal midwife and they can attend at the coop as well as having support if they do need to go to the hospital for any reason to help them.

1997: Child Protection Services (CPS) initiated the 'I'm an Aboriginal Dad' program (with the Mercy Hospital) to support Aboriginal fathers by helping them to engage with the community and approach Koori services on offer.

Theme 3: Validation and quality assurance

Currently, the health service is developing a 'RiskMan' incident follow-through process to pinpoint the staff member responsible for an Aboriginal patient being incorrectly identified as non-Aboriginal because they did not asked the question.

A mapping exercise was carried out a few years ago by the Health Information Manager at this hospital to target those staff members not asking the Indigenous question (when data is entered on the system, the staff member's name initials are recorded).

Internal audits are important to ensure issues around Indigenous Identification are isolated and identified. Data has been used in this hospital to discover which staff members are not performing according to process guidelines.

In the early 1980s Health Information Managers provided daily [inpatient] printouts for the AHLO to inform them how many Aboriginal inpatients there were in the hospital.

2003: a study carried out at the Mercy which highlighted the importance of capturing Aboriginal's father's identity.

2009–2010: Local benchmarking against Closing the Gap indicators.

In late 2010 the issue of identification was raised again and various hospital areas were asked to provide a monthly report on how many women had been identified as Aboriginal, with the aim of understanding what was happening prior to introducing new identification initiatives.

Theme 4: Cultural acknowledgment and safety

Flags at the hospital make a big difference to Koori patients and those driving past.



Aboriginal artwork throughout the hospital.
ICAP banner and Indigenous flag is in the entrance. Aboriginal and Torres Strait Islander desk flags have been placed at admission to A&E [accident and emergency] and acute.
An acknowledgment plaque introduced to the hospital.
Posters for all nations in palliative care.
This Health Service developed a Reconciliation Action Plan approximately 10 years ago in recognition of the Stolen Generations.
Identity posters with photos of community members posted in ACCHOs and doctors surgeries that are frequented by the community.
The AHLO visiting the maternity ward and supporting the non-Koori mothers (with Koori fathers).
<i>Koori Mail</i> and <i>Deadly Vibes</i> put in all waiting rooms, including dialysis to create a cultural safe place.
Indigenous menu introduction: the chef can cook fish/kangaroo for patients upon request.
A Healing Place has been established in the hospital.
The hospital prints a 'Quality of care' report in the district newspaper, which includes a section on the ICAP program at the hospital. It is hoped that this will change how people in community think about the hospital.
Services are provided for patients without a health care card (the past CEO wanted an open door policy for Aboriginal people).
We have developed a fridge magnet in the Aboriginal colours with the [AHLOs] mobile and office telephone number. This has been I think the biggest success as most Aboriginal homes I have been to have one!

Question 4

Respondents were asked to rate the importance of a pre-set list of initiatives in relation to achieving accurate Indigenous identification. Results are summarised in Table 10 (see next page) and Figures 21 and 22 (see next pages).

'Data collection training specific for registration staff including why and how to ask the question (hospital registration staff, funeral director and midwife)' was rated of high importance by 94% of respondents. This was followed by 'site-based Aboriginal Liaison Officer roles' (88%) and 'system enhancements: mandatory fields, removal of default values of "Not-Aboriginal" from registration systems' (85%).

'Data collection training' also had the greatest degree of agreement between informants. Only one informant rated it of medium

importance and one rated it N/A ('not in a position to comment on most of these at a service level and answers would vary from hospital to hospital'). No respondents rated it of low or no importance.

Distinction was made between two types of staff training. 'Data collection training specific for registration staff' was rated of higher importance (94%) than 'cultural respect training for all staff' (70%) in relation to the initiative improving identification.

A greater proportion of respondents rated each initiative of high importance than any other level of importance. No initiative received more than 18% of informants rating it of low or no importance combined. In most instances, as ratings of high importance decreased the spread of responses increased, and thus also the degree of agreement within the sample.



Table 10: Importance of initiatives to achieving improved Indigenous identification as rated by informants (number and proportion of responses)

Initiatives and policies	Level of importance					Total responses
	Not important	Low importance	Medium importance	High importance	N/A	
Training: Cultural respect training for all staff		3 (9%)	6 (18%)	23 (70%)	1 (3%)	33 (100%)
Training: Data collection training specific for registration staff including why and how to ask the question (hospital registration staff, funeral director and midwife),			1 (3%)	31 (94%)	1 (3%)	33 (100%)
Site-based Aboriginal Liaison Officer roles		1 (3%)	3 (9%)	29 (88%)		33 (100%)
Financial incentives rewarding positive identification of Indigenous patients (e.g. hospital-based WIES)	1 (3%)	5 (15%)	9 (27%)	15 (46%)	3 (9%)	33 (100%)
Accountability of line managers and senior managers (e.g. personal performance measures relating to identification)		1 (3%)	7 (21%)	21 (64%)	4 (12%)	33 (100%)
System enhancements: mandatory fields, removal of default values of 'Not-Aboriginal' from registration systems		2 (6%)	2 (6%)	28 (85%)	1 (3%)	33 (100%)
Development of National Best Practice Guidelines re identification	2 (6%)	4 (12%)	10 (30%)	11 (34%)	6 (18%)	33 (100%)
Materials encouraging Indigenous people to identify (posters and pamphlets at point of admission)		1 (3%)	8 (24%)	22 (67%)	2 (6%)	33 (100%)
Community-based visits to communicate why the information is collected and how it is used	3 (9%)	3 (9%)	10 (30%)	15 (46%)	2 (6%)	33 (100%)
Strengthened relationships between health service and local community-controlled organisation		2 (6%)	9 (27%)	19 (58%)	3 (9%)	33 (100%)
Routine feedback provided by government to health services and community organisations using the data collected	1 (3%)	2 (6%)	4 (12%)	24 (73%)	2 (6%)	33 (100%)
Site-based Aboriginal-specific health clinics	2 (6%)	4 (12%)	7 (21%)	14 (43%)	6 (18%)	33 (100%)



In Figure 21 (below) four initiatives shared the greatest proportion of respondents rating them of low and not important combined (18%).

These were:

- financial incentives rewarding positive identification of Indigenous patients (e.g. hospital-based WIES)
- development of National Best Practice Guidelines re identification
- community-based visits to communicate why the information is collected and how it is used
- site-based Aboriginal-specific health clinics.

When aggregating responses into two groups of informants there was varying agreement between the two groups (see Figure 22 on next page). There was general agreement between the two informant groups regarding the importance of ‘data collection training’ to

improving identification. This initiative had the highest proportion of informants in the policy/government/academic group rating it of high importance (94%) and the second highest proportion of ALO/hospital staff informants rating it of high importance (93%). It was also one of two initiatives with the smallest percentage difference between the two groups (1% difference).

The ‘Aboriginal liaison roles’ were rated of high importance by 100% of the ALO/hospital staff group and 73% of the policy/government/academic group. ‘Financial incentives’ was the initiative with the greatest variation between groups, followed by ‘relationships between health service and ACCHOs’. In both instances the ALO/hospital staff group rated these initiatives of much greater importance. There was also a difference between the proportions of informants in each group rating ‘cultural respect training’ of high importance.

Figure 21: Importance of initiatives to achieve improved identification as rated by all informants sorted in descending order of high importance (proportion of all responses by initiative)

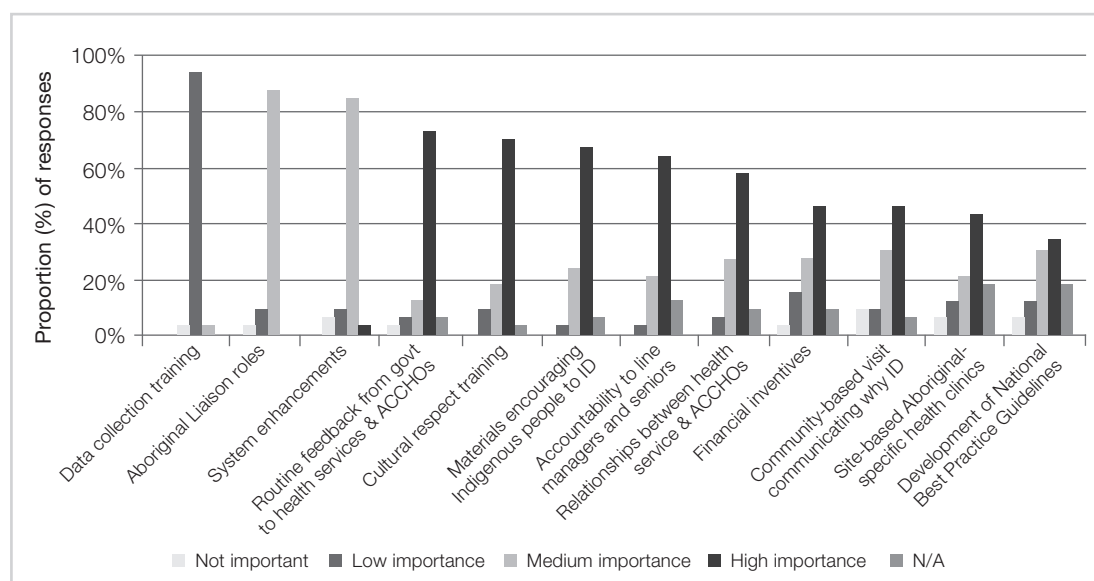
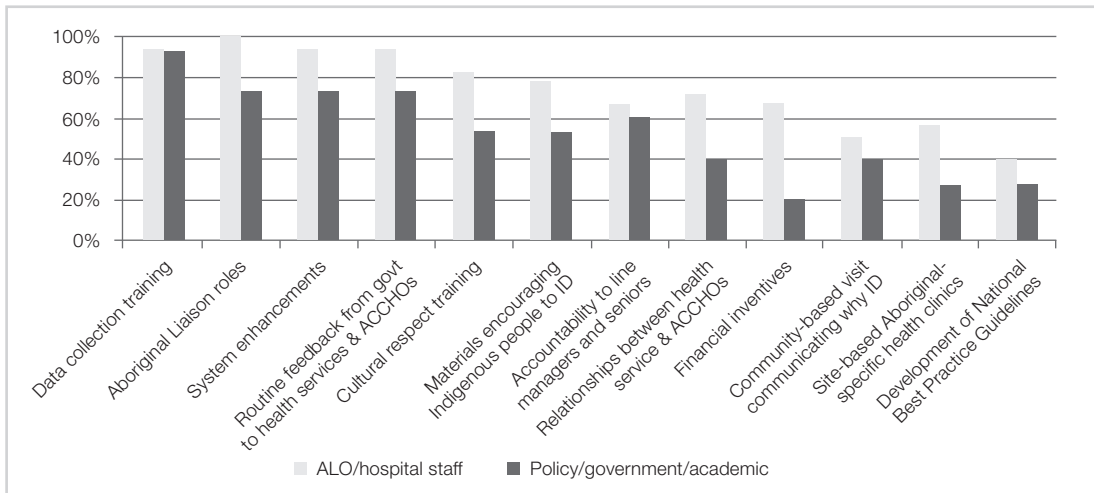


Figure 22: Proportion of informants rating initiatives of high importance, all informants by informant group



Figures 23–34 outline the distribution of responses by listed barrier for all respondents, and as disaggregated by the two informant

groups. Each figure is accompanied by five comments provided by informants. All comments are included in Appendix C.

Figure 23: ‘Cultural respect training for all staff’

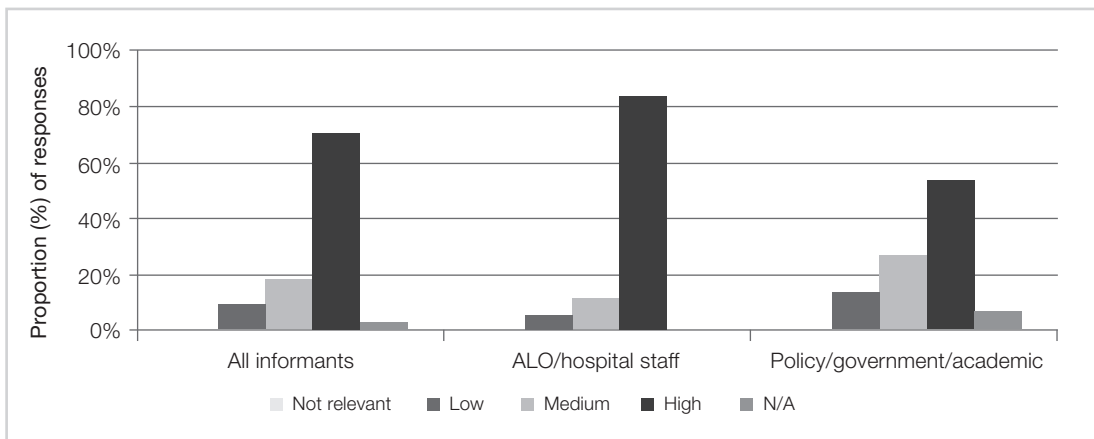


Figure 23 (see previous page) reports aggregated informant comments (direct quotes):

Cultural respect training may create a consciousness; however it is most likely to have a low impact on identification.

Cultural respect training provides an environment and atmosphere that values Aboriginal culture.

There is a place for cultural respect training, however, it can often create a divide between Aboriginal and non-Aboriginal patients and make participants feel intimidated and judged. Training that incorporates why Aboriginal patients may feel and act a certain way can be more

effective than historical perspectives. Most people who work in the health system are caring people—they are interested in how to best care for people so emphasising how identification can help patients get the supports they need can be effective.

All staff should be trained and aware through orientation regardless of their position, everyone from the top to cleaner. Everyone remembers the people who spoke during orientation.

This is important not only for funeral directors but for all BDM staff. Customer service staff need to be culturally aware to build customer confidence and break any perceptions.

Figure 24: 'Data collection training specific for registration staff'

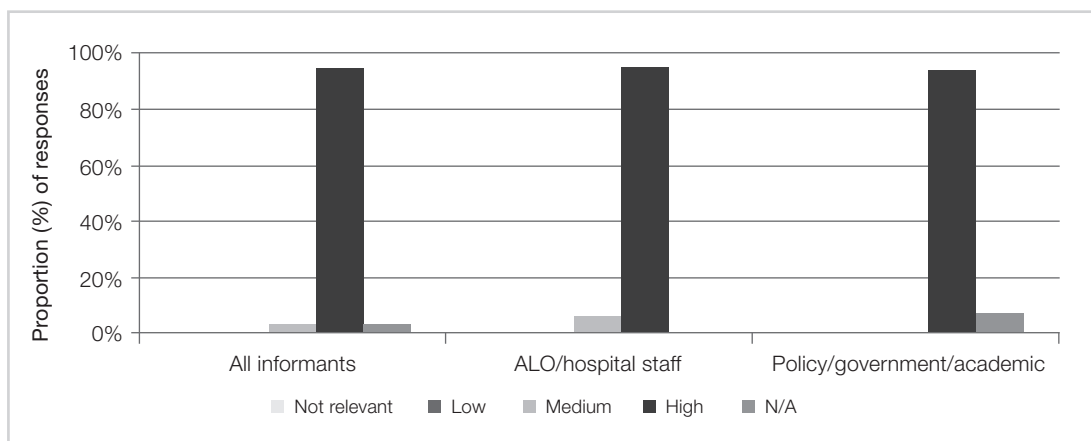


Figure 24 (above) presents aggregated informant comments (direct quotes):

Very important, however, there are limited policies regarding training for staff. A sustained program of staff training is required.

Data collection training specific for registration staff has to happen to highlight the significance of asking the question. Staff are busy but they need to know how important it is to ask.

Data collection staff need the support to:

- understand why the question must be asked and how they are a vital part of the process
- how to cope with asking the question of a grieving family
- feel confident to ask the question in the context of their work and their knowledge and understanding



- ongoing support so if have a bad experience they can talk over it and can learn in a non-threatening environment.

This training is good for all staff. However, [it's] not 100% the AHLO's role to train staff and having an outsider deliver training reinforces the importance of identifying.

Including the value of the question to health and wellbeing not just the link with WIES and hospital accreditation.

Figure 25 (below) identifies aggregated informant comments (direct quotes):

Site-based Aboriginal Liaison Officer roles are the most time and cost effective way to improve health/identification.

Site-based Aboriginal Liaison Officer roles are important to break down barriers

for achieving accurate identification. It has been identified that the presence of AHLOs in a health service often improves identification of Aboriginal patients.

It is intuitive that the support provided by Liaison Officers enables patients to recognise why they are being identified. Liaison officers are more important than financial incentives.

AHLOs are important in identifying Indigenous individuals; however they also rely on others to collect the information. Importantly, not every Indigenous mother wishes to interact with AHLOs, therefore other methods are needed to identify patients in a hospital setting.

Extremely important. There were 12 AHLOs in the beginning, I'm very proud of how the numbers have grown.

Figure 25: 'Site-based Aboriginal Liaison Officer roles'

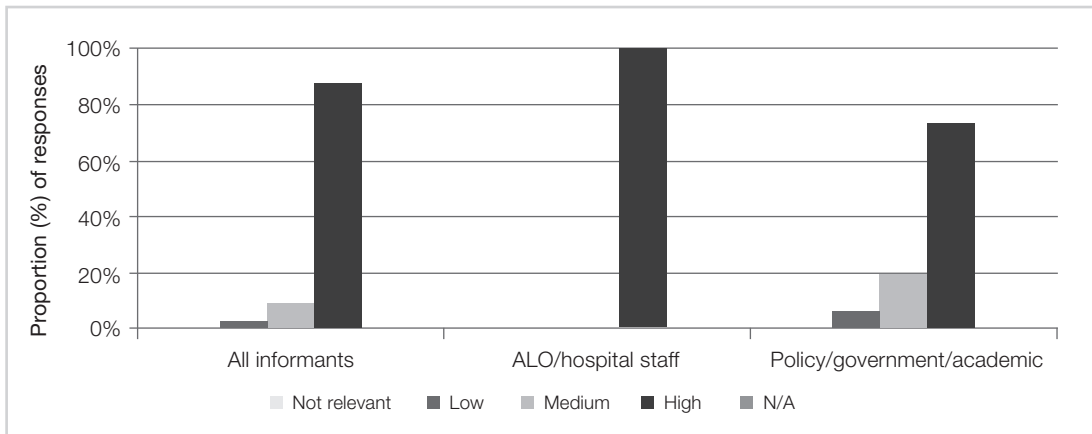


Figure 26: 'Financial incentives rewarding positive identification of Indigenous patients (e.g. hospital-based WIES)'

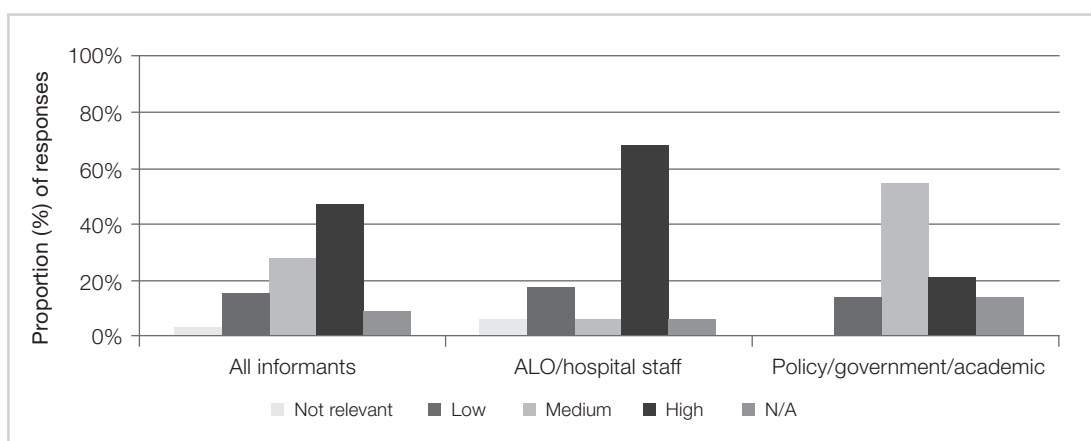


Figure 26 (above) reports aggregated informant comments (direct quotes):

The financial incentive is outrageous.

Financial incentives are likely to raise awareness, however, the reality of WIES is that it doesn't actually equate to increased dollars. Greater identification may just mean that the health service reaches its WIES cap quicker and the Aboriginal Health Program continues to compete internally for dollars. There is a risk in assuming a WIES loading that identification will result in a greater availability of funds to reinvest in Aboriginal programs, which is not necessarily the case. The WIES loading is really only beneficial to large health services with high volumes of Aboriginal attendances.

WIES incentives should be promoted as data quality improvement rather than Aboriginal funding. Evaluating how much each admission costs provides a clearer picture of how much needs to be invested in Aboriginal health.

WIES funding encourages the hospital to get things done. However, where does the funding go when identification is accurate?

The WIES co-payment is a good bargaining tool with hospital management. I have also used it as a tool for convincing staff that identification benefits the health service.

Figure 27 (see next page) identifies aggregated informant comments (direct quotes):

All staff members are accountable for identification because it is so important for the patient's care.

Accountability of line managers is important to identification and to how the question is being asked by staff members. The accuracy of data collected is difficult to measure.

Accountability of line managers is important—their performance should also be measured to ensure they are accountable for Aboriginal programs.

We're nowhere near it currently.

Very high, without them you have no support and you need them to help back the AHLO up.



Figure 27: ‘Accountability of line managers and senior managers’

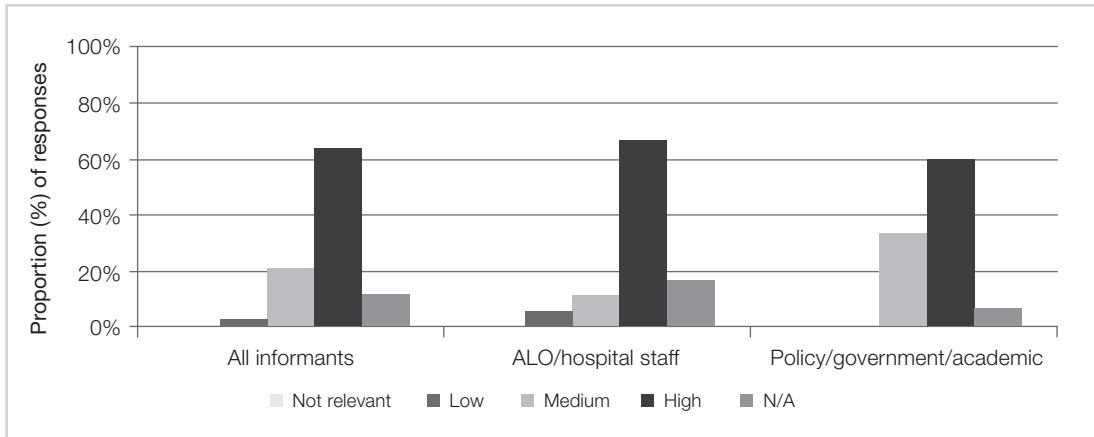


Figure 28 (below) presents aggregated informant comments (direct quotes):

Would be good to see a system enhancement that allows an Aboriginal individual to identify but opt-out of the AHLO being notified or involved.

System enhancements are important and easy to implement.

Removal of the default to ‘Not Indigenous’ was significant.

Once information is entered, it needs to be re-checked. An Aboriginal person may choose to identify in some instances and not in others.

[Initiative] Removal of the option of ‘not known’ status on online death registration system.

Figure 28: ‘System enhancements: mandatory fields, removal of default values of “Not Aboriginal” from registration systems’

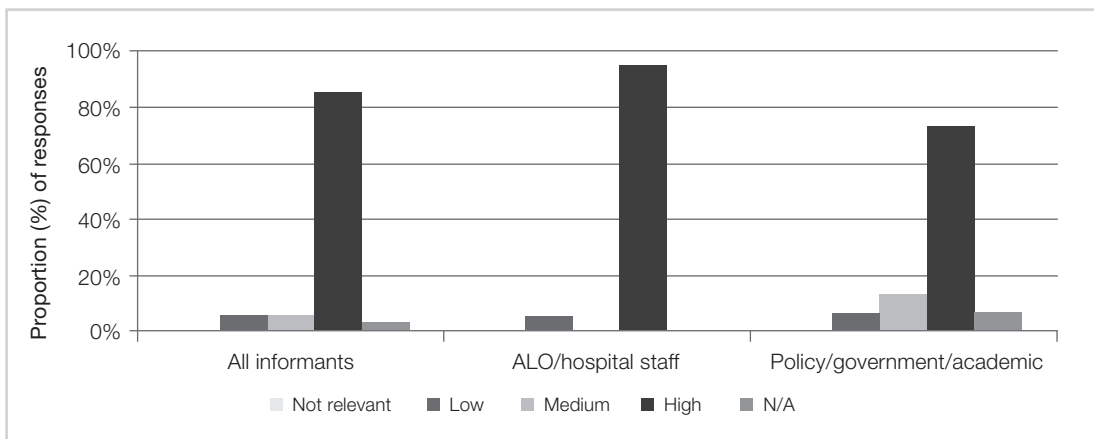
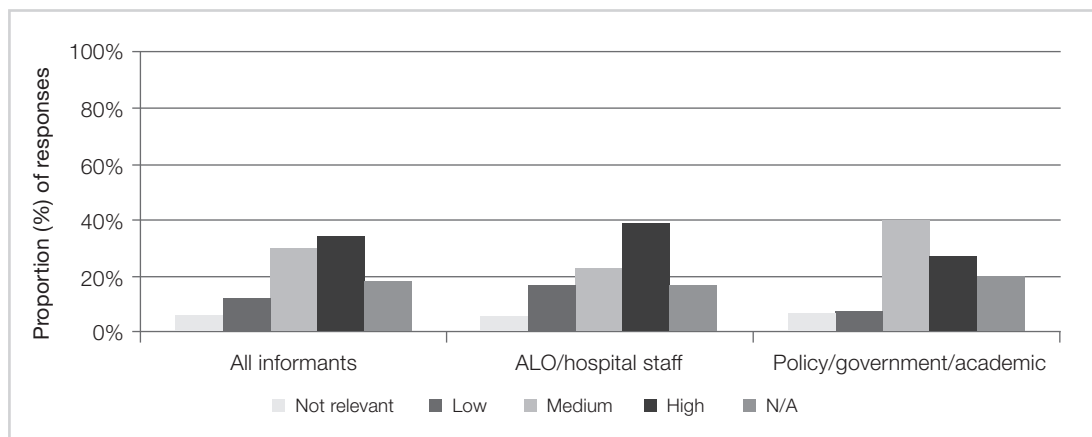


Figure 29: 'Development of National Best Practice Guidelines re identification'



There was a diversity of views in both informant groups regarding the importance of National Best Practice Guidelines to improved identification (see Figure 29 above). Less than 40% of informants in each group rated guidelines as highly important, while remaining responses were spread across no, low and medium importance and N/A.

Informant comments (direct quotes):

Good to have but I'm not sure if these Guidelines are effective.

Guidelines are more likely to impact positively if they are available electronically and matched with training.

I haven't seen these guidelines.

Government guidelines are an effective resource that can be taken to management to argue for policy change.

There are other better practices than the development of a National Best Practice Guidelines for the improvement of Aboriginal identification.

Figure 30: 'Materials encouraging Indigenous people to identify (posters and pamphlets at point of admission)'

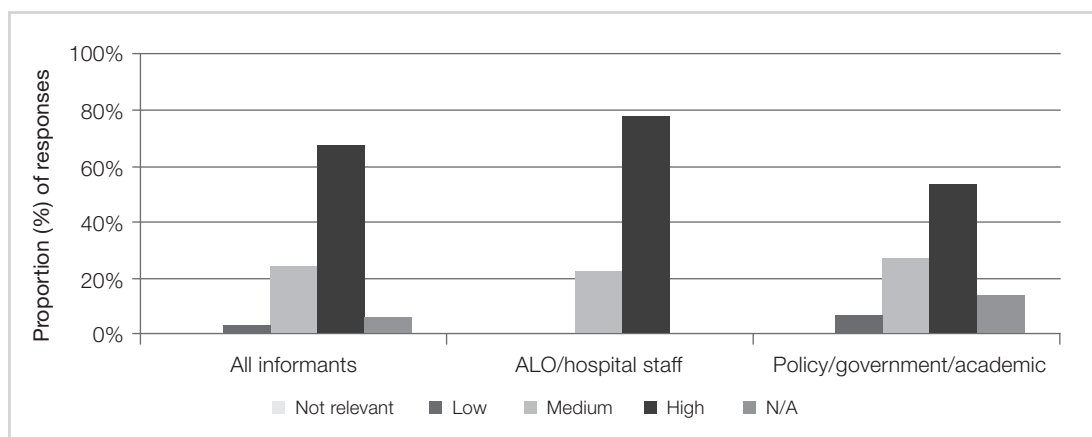


Figure 30 (see previous page) reflects that a large proportion of the ALO/hospital staff group of informants considered materials encouraging people to identify was highly important (78%). Informants in the policy/government/academic group were in less agreement; 53% believed they were highly important, whereas the remaining 47% was distributed across low, medium and N/A validity.

Informant comments (direct quotes):

Very important not only for identification but also for promoting a culturally-safe environment.

Social marketing is important for achieving accurate identification (e.g. DVDs or other paraphernalia to promote health services, the care and services provided. This may be helpful for community understanding and improving negative perceptions).

I am not sure if materials used to encourage Indigenous people to identify are important. Staff members are likely to remove posters and pamphlets at point of admission. Although it's important for the community to see photos of community members, in the

end it's all about how the question is asked and the knowledge of the person answering.

If you put up a poster, make sure it says the right things.

Very useful—jolt the memory of staff.

Figure 31 (below) reports aggregated informant comments (direct quotes):

These haven't happened directly but when the community has been involved, it has been effective.

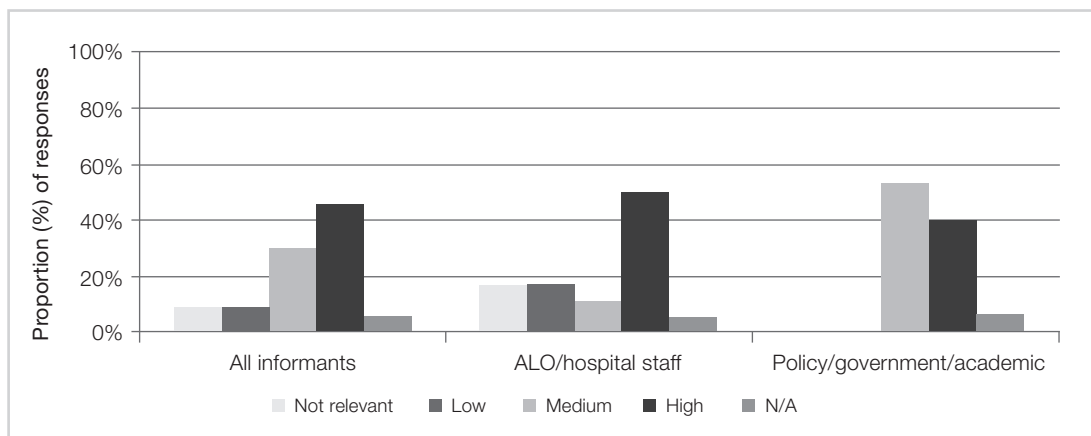
How do you get to people not using community-controlled organisations?

Communicating why the information is collected and how it is used may be perceived in a negative way and may not get Indigenous people to identify. Identifying Indigenous status is a personal choice.

This happens one-on-one in the community.

Oral health promotion at youth festivals and schools encourage identification. Hospital newsletter and radio recording also provides information on what services are provided at this hospital.

Figure 31: 'Community-based visits to communicate why the information is collected and how it is used'



In Figure 32 (below) more than 72% of policy/government/academic informants believed that the relationship between health services and ACCHOs was of high importance to improving Indigenous identification, whereas far fewer of the ALO/hospital staff group agreed (only 40% rating it of high importance).

If there are good relationships between community and health services then maybe, but for most hospitals no. This would not be a priority for improving identification.

This is one of the premises of ICAP; strengthened relationships between hospitals and ACCHOs are important for ensuring overall success.

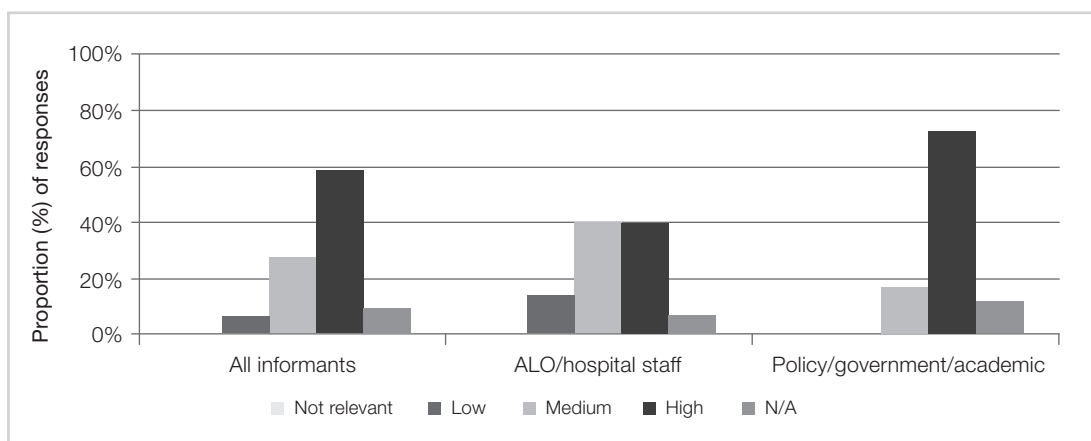
Informant comments (direct quotes):

More needs to be done with social marketing through the Aboriginal community to promote the hospital as a safe place to be, provide information on hospital services and strategies to improve care for Aboriginal patients, and inform Aboriginal patients what they have the right to expect and what to do if their expectations are not met.

Community Controlled Organisations are in a good position to inform people prior to a hospital visit; some referrals come through these organisations.

Aboriginal oral health group quarterly meetings have been important in strengthening relationships.

Figure 32: 'Strengthened relationships between health services and local community-controlled organisations'



In Figure 33 (below) more than 70% of informants in each group regarded routine feedback provided by government to health services and community organisations using the data collected as highly important to improving identification.

Informant comments (direct quotes):

This is an important indicator of Aboriginal people's access to mainstream acute health services and can prompt the need for improved patient identification strategies and inform service planning.

Feedback to organisations is critical. Really sell the point that health services can't offer a service to a community if they don't identify the community.

Analysis provided by the Department does not go deep enough to be useful for an individual service. In addition, services are likely to object to their performance being publically scrutinised in great detail. Health services should [make] use of their own data to perform deeper analysis and research into local issues. Data should be used to start conversations within the health service.

We need more of it. Had more hope with the AHLO data and Koori Health Counts reports, which were brilliant. It was good to have in hard copy, helps benchmarking with other hospitals for chronic conditions.

BDM should not do any community profiling—it is appropriate to give data back in other circumstances.

Figure 33: 'Routine feedback provided by government to health services and community organisations using the data collected'

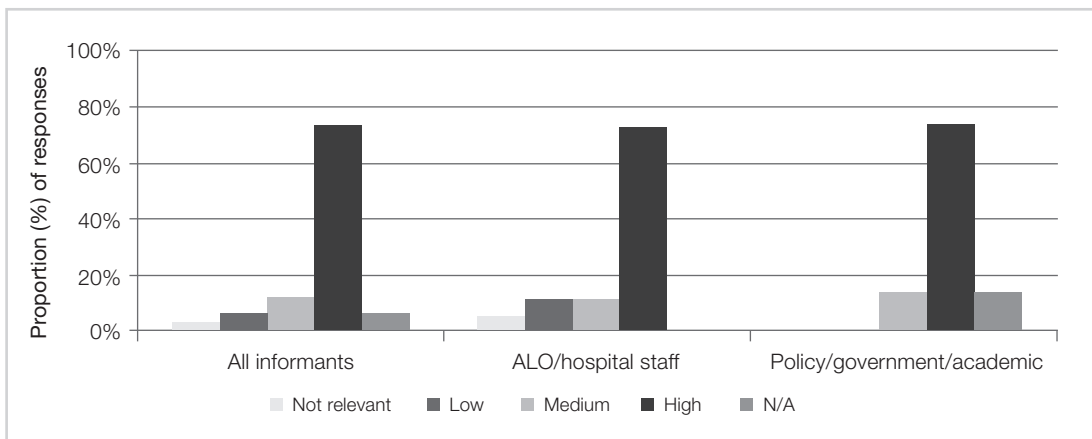


Figure 34 (below) presents aggregated informant comments (direct quotes):

Site-based Aboriginal-specific health clinics are likely be beneficial, however, they're not critical for Aboriginal patient identification.

Site-based Aboriginal-specific health clinics are important for encouraging identification (e.g. the presence of barriers such as shame factor and community fall-out may discourage willingness to identify in a general health clinic).

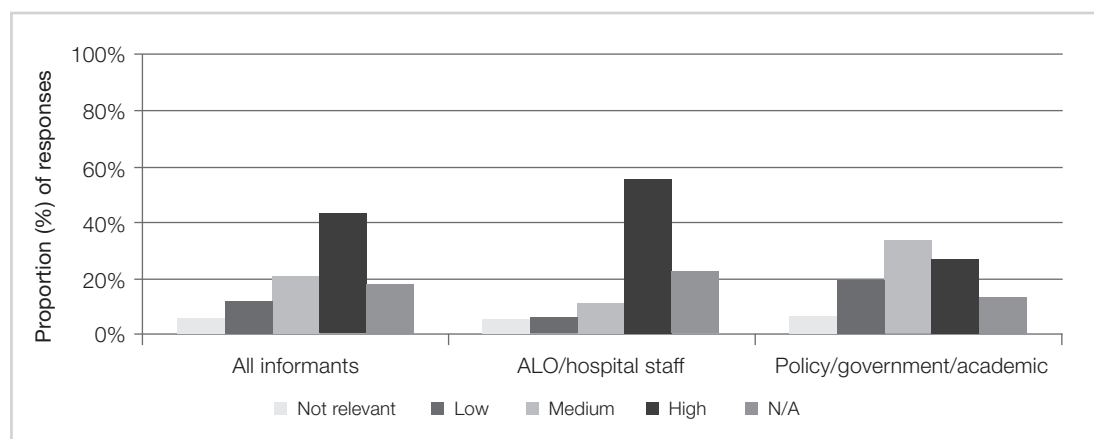
Site-based Aboriginal-specific health clinics provide easy entry into a big organisation for specific clients. These services help build trust and good rapport with patients

which is good for quality of care, but it's debatable how effective they are in terms of identification in the hospital more broadly.

Aboriginal-specific clinics may actually be a deterrent to identification when a patient doesn't want Aboriginal staff to know their business.

Workers (Koori maternal nurses, in home workers, coop nurses, Maternal and Child Health (MCH) nurses, and preschool support officers) assist parents complete the birth registration forms. Children can only be enrolled in schools if birth certificate is provided. Children's official name and date of birth must be used to access their VIC student number.

Figure 34: 'Site-based Aboriginal-specific health clinics'



Question 5

Informants were asked their views as to the most effective initiatives implemented since 1980 to achieve accurate identification. Respondents could identify as many initiatives as they wished, which resulted in a combination of local and State-wide initiatives.

Thematic analysis of responses resulted in 12 categories of initiatives:

- staff training (23 mentions)
- AHLOs and Aboriginal staff (19)
- system enhancements and data improvements (12)
- government bodies, coordination and key initiatives (8)
- the ICAP program (6)
- hospital Aboriginal WIES supplement (6)



- Aboriginal flags and artwork (5)
- data validation (5)
- promotional materials (4)
- community engagement and education (3)
- accountability and accreditation (2)
- other (5).

Staff training was mentioned most often (23 times), followed by AHLOs and Aboriginal staff (19), system enhancements/data improvements (12), and government bodies, coordination and key initiatives (8).

It is important to note that although the ICAP program was explicitly mentioned six times, the ICAP program encompasses a number of the other initiatives, such as AHLOs, Aboriginal artwork, promotional

materials, financial incentives (Aboriginal WIES supplement) and staff training. Therefore, credit allocated to these initiatives is also attributable to the ICAP program.

Of the 12 comments relating to system enhancements/data improvements, five were in reference to the introduction of a variable to record the Indigenous status of the baby in the VPDC in 2009. This initiative enabled birth data to capture the status of the father, as well as the mother, for the first time, which was previously recorded in isolation.

Table 11 (below) lists categories of initiatives resulting from thematic analysis, the number of times they were mentioned by informants and examples of these comments/mentions (a full list of answers to Question 5 is provided in Appendix C).

Table 11: Initiatives reported by informants in Question 5 to have been the most effective implemented since 1980 to achieve accurate identification

Category (from thematic analysis)	No. of times mentioned	Examples of effective initiatives (direct quotes)
Staff training	23	<p>The AHLO presentation at staff orientation has made a difference with some staff. It's too open and not in-depth though.</p> <p>Staff training and Identification workshops at this hospital.</p> <p>General Practitioner education programs.</p> <p>Education programs for midwifery students and handouts on how to ask the question.</p> <p>Education for student doctors and midwives.</p> <p>Cross-cultural training is important for understanding why asking the question is important.</p> <p>Continuous education of data collectors: ongoing due to turnover of staff.</p> <p>Cross cultural training in the hospital—it would be better with two people and not solely relying on the AHLO.</p> <p>Educating ward clerks and emergency staff. The AHLO needs to know Aboriginal patients are in the hospital.</p>



<p>AHLOs and AHLOs and Aboriginal staff</p>	<p>19</p>	<p>Introduction of the AHLO Program in the 1980's, and the continued growth in the number of Liaison roles today.</p> <p>AHLOs active on the ground within hospitals. These roles have a positive impact and ensuring Aboriginal patients not identified at registration are picked-up later.</p> <p>AHLOs were vital to getting Aboriginal data on the agenda, with the support the DoH provided.</p> <p>The Koori midwife role. Word of mouth means women now offer their Aboriginal status and ask for the Koori midwife.</p> <p>The work of AHLO's, initially in the early days... at the Children's Hospital has since spread out into all aspects of health.</p> <p>The employment of AHLOs has been the most effective initiative at this hospital.</p> <p>Employment of a Koori Customer Service Officer (re RBDM).</p> <p>Establishment of Aboriginal-identified roles in government agencies (with VCAT [Victorian Civil and Administrative Tribunal] exemptions) and the broadening of Aboriginal-specific Units across government and Senior Aboriginal people.</p>
<p>System enhancements and data improvements</p>	<p>12</p>	<p>Systems: 1994 standardisation of admission forms. Changes to coding were a barrier to identification when the #2 code changed to Torres Strait Islander.</p> <p>Introduction of the variable to record the Indigenous status of the baby in perinatal data.</p> <p>Removal of default to 'not Indigenous' so that staff at registration don't take it upon themselves to make a decision.</p> <p>Linking identification with finance e.g. WIES loading. Other initiatives are also important, such as staff training and system enhancements. When change is system-wide, and when Administrators are driving change, it signals behavior.</p> <p>Data quality improvement procedures at BDM.</p>
<p>Government bodies, coordination and key initiatives</p>	<p>8</p>	<p>The Victorian Aboriginal Affairs Taskforce.</p> <p>Whole of government coordination and approach to Aboriginal affairs including: Senior Officers Group, Secretary's Group and Aboriginal Affairs Taskforce. The social determinants play an important role in health.</p> <p>Closing the Gap initiatives: These initiatives created awareness and engaged people to take Indigenous identification on board. They have also increased people's interest and involvement in Aboriginal Health.</p> <p>The Indigenous Access Program and resulting Indigenous Access Fund (re RBDM).</p> <p>Establishment of Justice Service Centres (re RBDM).</p>
<p>The ICAP program</p>	<p>6 (other initiatives listed separately also a component of ICAP)</p>	<p>I'm very proud of the ICAP Program. It has created relationships in a national and State level and its success is evidenced by the increase in AHLO numbers.</p> <p>An overarching aim of the ICAP Program is to improve Aboriginal identification. The program has been an effective initiative, to get Aboriginal identification back on the agenda.</p> <p>The WIES copayment and ICAP program have been effective at making Aboriginal health and identification the [hospital's] responsibility rather than the Department of Health's responsibility.</p> <p>Department of Health Policy on identification (see ICAP resources kit).</p>



Hospital Aboriginal WIES supplement	6	<p>Linking identification with finance e.g. WIES loading.</p> <p>WIES loading: it was an overall driver to improve identification and with that came compliance/reporting requirements.</p> <p>The VAED WIES loading; hospitals talk in dollars.</p>
Aboriginal flags and artwork	5	<p>Flags outside health services—patients go where they see the flag.</p> <p>The use of materials/posters through ICAP and having Aboriginal paintings on the wall. These are a talking point.</p> <p>Flags outside the hospital and paintings make the hospital an inviting and friendly environment for Aboriginal people.</p> <p>Resources for the community including magnets and posters.</p>
Data validation	5	<p><i>Koori Health Counts</i> publications have been a valuable source of data for public hospitals and tool for comparing performance with peers.</p> <p>Cross-checking between AHLO, Perinatal and VAED data; AHLO data was assumed to be the most accurate, but it did not cover all hospitals.</p> <p>Local benchmarking against Closing the Gap targets and benchmarking against other hospitals on key indicators.</p>
Promotional materials	4	<p>The use of materials/posters through ICAP and having Aboriginal paintings on the wall. These are a talking point.</p> <p>Promotional materials/identity posters for all settings: hospitals, general practice, funeral directors.</p> <p>Local hospital circulars generating interest.</p>
Community engagement and education	3	<p>Community engagement—telling community what services are on offer for them at the hospital.</p> <p>Community education outlining why identification is important, how the collected data is used.</p> <p>Resources for the community including magnets and posters.</p>
Accountability and accreditation	2	<p>Health services required to report on indicators relating to Indigenous health through Quality of Care Reports.</p> <p>Processes for holding the hospital accountable, for example the WIES dollars and accreditation.</p>
Other	5	<p>It's difficult to rank efforts. It takes time and depends on the development of trust between the community and people in government regarding why/how the information will be used.</p> <p>The issue needs a full frontal approach in all directions. There was a significant level of mistrust in the past.</p> <p>Who knows? It hasn't been monitored properly.</p> <p>I believe that the staff are able to arrange for Indigenous status to be corrected at the hospital level.</p>



Question 6

Informants were asked if they were aware of any evaluations of initiatives implemented to improve Indigenous identification or evidence of effectiveness. Only 17 of the 33 informants (52%) provided a response to this question. One informant commented that 'the lack of evaluations of initiatives or evidence of effectiveness in this area is a major problem'. In Question 5, in response to the question of effectiveness of previously implemented initiatives, an informant responded, 'Who knows? It hasn't been monitored properly.'

Table 12 (see next page) lists informants' responses in two categories: local evaluation activity and State-wide evaluation activity. Responses include evaluations of programs specifically implemented with the aim of improving identification and those that rely on the identification of patients, babies and deceased but are not necessarily implemented with the aim of improving identification.

Examples of evaluation or validation activities with the specific aim of monitoring identification included:

- evaluation of the ICAP program, including rates of identification
- local analysis of identified patient numbers as a potential indicator of effectiveness of health service initiatives (such as staff training)
- evaluation of cross-cultural training at the health service indicating that staff members are more comfortable asking the question
- validations of the perinatal data to evaluate improvement of Indigenous identification in 1992–1993 and 2000–2001
- pre-/post-participant evaluation forms for the Data Quality Training pilot conducted by DoH in 2007 (not publicly released)
- the 'Looking at Identification of patients in hospitals: Evaluation of the identification processes' study conducted by Onemda and La Trobe in 2002
- AIHW hospital Indigenous identification audits in 2007 and 2011.



Table 12: Summary of responses to Question 6 regarding evaluations of initiatives implemented to improve Indigenous identification and/or evidence of effectiveness

Local evaluation activity (direct quotes)
<p>A number of health services have used data to support business cases to justify AHLO roles, whereby substantial increases in numbers of identified Aboriginal patients have coincided with the appointment of AHLOs.</p> <p>Local benchmarking against Closing the Gap targets.</p> <p>Through the partnership with the ACCHO, the health service can evaluate if it has really made a difference and identify what indicators should be focused on in the future.</p> <p>Evaluation of cross cultural training at the health service has indicated that staff are more comfortable asking the question and numbers of Aboriginal patients being identified have been increasing.</p> <p>Training appeared to be effective at this hospital. The number of identified patients tripled, departments have requested repeat training and participant feedback forms were very positive.</p> <p>Ongoing evaluation of staff roles.</p> <p>Hospital accreditation highlighted the importance of the AHLOs' role in facilitating access to services.</p>
State-wide evaluation activity (direct quotes)
<p>Participant evaluations from Aboriginal patient identification training sessions.</p> <p>Ongoing review of numbers of identified patients in the VAED/VEMD.</p> <p>Emergency Department project evaluation.</p> <p>Aboriginal Health Promotion and Chronic Care (AHPACC).</p> <p>Koori Maternity Services evaluation.</p> <p>AIHW [hospital Indigenous identification] audits in 2007 and 2011.</p> <p>The ICAP Program has been evaluated and reported to have shown some improvement in rates of identification. There is room for more improvement to be made regarding Aboriginal people self-identifying, staff asking the question and whether there has been an increase in the number of Aboriginal people visiting hospitals.</p> <p>In 1992–1993 and 2000–2001: the Research and Liaison Midwife conducted (at least) two validations of the Perinatal data to evaluate improvement of Indigenous identification.</p> <p>2002: 'Looking at Identification of patients in hospitals': Evaluation of the identification process conducted by Onemda and La Trobe, a precursor to the increase in WIES co-payment loading from 10% to 30%.</p> <p>2009 Road Show: There was an internal report regarding locations visited and services provided with the Indigenous Access Program.</p>



Question 7

Respondents were asked to consider whether they believed factors outside the health system impacted on an Aboriginal person's willingness to identify. All respondents (100%) answered 'yes' to this question. Thematic analysis resulted in 11 common themes:

- interaction with, or fear of interaction with, government agencies and programs (21 mentions)
- government policies, e.g. child removal (11)
- the National Apology (11)

- cultural safety within health services (10)
- media reports (9)
- racism and social stigma (6)
- senses of pride or grief/helplessness (5)
- education (4)
- family experiences and storytelling (4)
- community conflict (3)
- other (7).

A summary is provided in Table 13 (below). All responses are included in Appendix C.

Table 13: Summary of responses to Question 7 regarding factors outside the health system impacting on an Aboriginal person's willingness to identify

Factor	No. of times mentioned	Examples of effective initiatives (direct quotes)
Interaction with, or fear of interaction with, government agencies and programs	21	<p>Previous/current interaction with government agencies, e.g. if having problems with housing, or having been in trouble as an Aboriginal person anywhere else like child protection or juvenile justice.</p> <p>All policies of government have an impact including personal and familial contact with police, housing, child protection etc.</p> <p>If a person is a member of the Stolen Generation that may not wish to identify due to a fear of hospitals (due to intervention in the past and child protection).</p> <p>Some patients come into hospital with complex issues involving other services (e.g. DHS & children removal).</p> <p>Some patients are unsure why the information is being collected and fear external agencies will be contacted (e.g. 'They're going to call the Police on me').</p> <p>Past treatment from organisations such as Centrelink and housing whereby people are fobbed off so many times that they don't bother anymore.</p> <p>Fear of interaction with other services such as housing, the police, and Centrelink. This may lead to individual choosing to identify in some places but not others.</p> <p>Acknowledgment of ownership of land—the local Council partnership with the Wurrunjerrri people.</p> <p>The Aboriginal Justice Agreement, Direct Service Agreements and work of Aboriginal Planning Officers.</p> <p>Public sector jobs and Aboriginal community organisations possibly led to a greater willingness to identify.</p> <p>Empowerment and entitlement through the development of the Recognised Aboriginal Parties (RAP) in Victoria.</p> <p>Census time.</p>



Government policies, e.g. child removal	11	<p>Older individuals might fear identifying as Aboriginal from past experiences (e.g. Stolen Generation).</p> <p>The Stolen Generations continue to impact current beliefs and behavior. This is the reality of their childhood, it's not distant history. The belief that if I identify, my kids will be taken away.</p> <p>Aboriginal people becoming Australian citizens only in 1967.</p> <p>The 'Half Caste policy'; legislation telling people whether they are Aboriginal or not by the colour of their skin.</p> <p>Community conflict, previous racism and history.</p> <p>The Stolen Generation.</p> <p>Political climate at the time [of identifying].</p>
The National Apology	11	<p>The 'Apology': people felt better about being an Aboriginal patient, but I'm not sure if it had an impact on an Aboriginal person's willingness to identify.</p> <p>The 'Sorry statement' is unlikely to have had an impact on practical levels; however, it has created a platform to work from, increasing support and engagement with the Department of Health (e.g. Closing the Gap, inclusion of Aboriginal health on the agenda and more people in the Department engaged with improving Aboriginal health).</p> <p>The Apology: It is easy to say 'Sorry' but real actions have not been shown since. This is the community's point of view.</p> <p>The 'Sorry' statement is unlikely to have had an impact. People need to see action rather than more rhetoric.</p> <p>The 'Apology' and 'Closing the Gap' initiatives may have had a greater impact on the non-Aboriginal population than on the Aboriginal community.</p>
Cultural safety within health services	10	<p>A perception that identification may lead to stigmatisation in some sense, of getting singled out from the rest of the community. Judged as a poor parent because they're Aboriginal.</p> <p>A willingness to identify relies on an individual's sense of safety.</p> <p>Experiencing prejudice: patients may fear they will be treated differently/ discriminated or singled out if they identify.</p> <p>Racist preferences in services.</p> <p>Flying the Aboriginal flag and posters—cultural safety.</p> <p>Familiar faces fronting health promotional campaigns might have a positive impact on identification.</p> <p>Who's asking the question? It should be more of a Koori to Koori interaction to get around issues of trust.</p> <p>Unwelcoming environment likely to have a negative impact on person's willingness to identify.</p> <p>Community events hosted by a health service helps promote the service and give back to the community (e.g. Christmas BBQ, kids' presents from Santa). This enables health service staff to engage with the community at a grass-roots level. The local council can get involved, staff can volunteer, and a community member's experience with the service is likely to impact on their willingness to return.</p>



Media reports	9	<p>Media reporting on Aboriginal crime—stereotyping.</p> <p>Aboriginal health is in the limelight, which may impact on an Aboriginal person's willingness to identify.</p> <p>Media reports regarding Indigenous issues (positive and negative).</p> <p>Pauline Hanson's 1996 maiden speech to the House of Representatives and the NT [Northern Territory] Intervention are likely to have had a negative impact on an Aboriginal person's willingness to identify.</p> <p>Negative material in the media can impact an Aboriginal person's willingness to identify and is likely to affect staff members in health services who may consequently have a more aggressive approach towards Indigenous patients.</p> <p>'Closing the Gap' initiatives may have had a greater impact on the non-Aboriginal population than on the Aboriginal community.</p> <p>The overall increase in awareness makes people feel more comfortable and gives them an assurance that they won't be treated differently.</p>
Racism and social stigma	6	<p>The broader social climate including periodic shifts in public expressions of racism, which dictates whether people feel comfortable talking about Aboriginality. An open social climate makes people feel less 'at risk'.</p> <p>Plethora of negative experiences of racism outside the health system.</p> <p>Social stigma: due to perceived disadvantage and fear of negative treatment.</p> <p>Community conflict, previous racism and history.</p>
Senses of pride or grief/ helplessness	5	<p>Cultural heritage and increasing pride in culture/heritage.</p> <p>Growth in community pride e.g. football and netball teams.</p> <p>A person's strength in their identity.</p> <p>It is sometimes difficult for an Aboriginal woman to feel comfortable and being proud of who they are.</p> <p>Grief and a state of helplessness is likely to influence an Aboriginal person's willingness to identify.</p>
Education	4	<p>School education regarding Indigenous Australia likely to have an impact on person's willingness to identify (e.g. How it is taught, if at all).</p> <p>Health education—understanding the health system.</p> <p>Social determinants (e.g. housing and social factors).</p> <p>Institute of Koorie Education at Deakin University has returned positive results. It helps build people's self-esteem.</p>
Family experiences and storytelling	4	<p>History [is] often passed on verbally in this population and therefore the beliefs and experiences of grandmothers and mothers are passed down to women, particularly first time mums.</p> <p>Historical government policies are still impacting on people today, passed through generations through story telling (only 4–5 generations).</p> <p>Previous experiences of the emergency department personally and within the community are likely to have an impact since people's beliefs are shared verbally between individuals in the community.</p> <p>Family group are likely to be influencing each other's likelihood of identifying based on individual experiences and understanding of benefits to identifying, impact on care and accessibility.</p>



Community conflict	3	<p>Community conflict, previous racism and history.</p> <p>An Aboriginal person might not wish to identify due to a community conflict with an AHLO.</p> <p>Koori health services may not be chosen for use due to community fall-out, which may also lead to an unwillingness and fear of identifying.</p>
Other	7	<p>There are likely to be many and varied influences and incidents in an individual's life (positive and negative) impacting on whether a person discloses their Aboriginality.</p> <p>Messages from Aboriginal leaders e.g. Pat Dodson's public resignation from his founding chairmanship of the Council for Aboriginal Reconciliation in 1977 due to disillusionment and loss of faith. This sent out a big message to the community.</p> <p>Aboriginal patients may get insulted if asked/not asked the identification question e.g. 'You're not Aboriginal are you?'</p> <p>If a patient has mental health or drug and alcohol issues, they are unlikely to identify.</p> <p>Travel money and time: services may be readily available, however travel time and money can act as barriers to accessing services.</p>

Topic 3: Recommendations for future policy focus and key stakeholders

Questions 8 to 10 in the questionnaire related to future policy focus and stakeholders for future engagement in efforts to improve identification.

Question 8

In Question 8 respondents were asked to suggest where they thought future policy should focus to achieve improved identification. In Question 10 respondents were asked to restrict their views to one initiative that they would fund/introduce/expand in the future.

Thematic analysis resulted in nine themes for each informant group. Responses have been summarised under these themes for each informant group (see Tables 14 and 15 on following pages). A full summary of responses from each informant, sorted into informant group, is included in Appendix C.

Analysis resulted in very similar themes between the two informant groups, with only two exceptions (highlighted in Table 14 on next page).

Respondents in the policy/government/academic group commented on the appropriateness of the national definition of an Indigenous person, and identified support for data validation activities such as data matching/linkage.

The ALO/hospital staff group commented on the role of financial incentives and sought clarification of the role of health services in the reinvestment of nominal WIES dollars in Aboriginal programs. Members of the group also frequently commented on the importance of staff training and proposed several models of training for different stakeholder groups.

Both groups commented on the imperative for system improvements, including feedback from DoH to health services with



analysis of local data, increased numbers of Aboriginal staff to support Aboriginal clients, and improved cultural safety and patients' increased willingness to identify.

Both groups also suggested factors outside the health system that required attention but have the potential to impact on identification. These included socio-economic factors such

as housing, education and employment (which have the potential to impact on self-esteem and pride in one's identity), and community views of government social services.

Comments also included societal change to increase respect for Aboriginal culture in the mainstream. Examples of direct quotes are reported in Table 15 (next page).

Table 14: Themes resulting from thematic analysis of responses to the question 'Where do you think future policy should focus to achieve improved identification?' by informant group

Policy/government/academic informant group	ALO/hospital staff informant group
Systems and processes	Systems and processes
Education and training for staff	Education and training for staff
Aboriginal staff	Aboriginal staff
Influencing willingness to identify	Influencing willingness to identify
Feedback mechanism	Feedback mechanism
Accountability	Accountability
Factors outside the health system	Factors outside the health system
National definition	Financial incentives
Validation	Promotional materials



Table 15: Examples of responses provided by informants (direct quotes)

Theme	Policy/government/academic informants (direct quotes)	ALO/hospital staff informants (direct quotes)
Systems and processes	Fund technical system improvements to efficiently improve the quality/integrity of the data in records at BDM. Build a capacity in the Register to allow for subsequent identification to capture the changing propensity to identify.	Many initiatives are required so that if a person is missed in one they can be picked up in another.
	System focus to ensure software efficiency and accurately prompting staff to ask the question at different points throughout the care of the patient	Inconsistency between datasets is a major issue. National and State dataset consistency should be a priority to achieve improved identification.
	Hospital processes for certifying death records.	A system enhancement to allow the patient to identify but opt out of AHLO involvement.
	Institutional change management: Start in one institution and get it right before implementing across the State. Break down the processes to identify where the problem is, and once the source/s are identified, it is easier to address the problem.	It would be useful if AHLOs had a contact within the Health Department that they could go to discuss issues at a site level, where they could assess the issue and potential[ly] speak to management.
	Just targeting one thing doesn't work. We need systematic, sustainable change within health services. All hospital staff, Aboriginal and non-Aboriginal should be involved and accountable. Currently, if a Project Officer walks out the door, the project falls down.	



Education and training for staff	<p>Greater resources to deliver more staff training.</p> <p>Managerial support and training for staff to ask the question in the right manner to avoid making a person feel threatened by the question.</p> <p>Diminish funding focused on training staff members to ask the Indigenous question, particularly in areas where the proportion of Aboriginal population is small compared to the total population.</p>	<p>A gap persists in staff training. Nothing eventuated from the 2007 DHS staff training pilot. A sustainable training package is required that includes:</p> <ul style="list-style-type: none"> • Online resources • Train the trainer model • Links to further information • Starting point for cultural competency. <p>Staff training delivered by DHS and the Koorie Heritage Trust in collaboration with the AHLO: Emphasising the link between the questions and the services/treatment made available to the patient in hospital and after discharge. A second question should follow: 'Do you want assistance from the Liaison Officer or another worker?'</p> <p>Staff training and social marketing:</p> <ul style="list-style-type: none"> • to provide staff with cultural understanding and empower them to explain why the question is being asked • to promote awareness amongst staff of the importance of identifying, which may lead to an improved hospital experience for Aboriginal clients. • (re future training: ask staff members to identify Indigenous identification barriers they believe are present and what initiatives should be introduced for further improvement). <p>A short online training program for Victoria would be a great addition to face-to-face training. Medical staff are required to partake in online training for other clinical competencies. The video could include a number of Aboriginal leaders sharing their stories from communities across the State. Some AHLOs don't feel comfortable delivering training and this resource could pick up those people not attending formal sessions.</p>
Aboriginal staff	<p>Employment of Aboriginal staff in a variety of roles (AHLOs, non-clinical positions, executive positions, support roles, case management, out-patient follow up).</p> <p>Increase the numbers of Koorie midwives also due to trust, understanding cultural factors and capitalising on positive word of mouth in the community. Women will talk to each other about which midwives are good, which hospitals they feel comfortable in.</p> <p>Do we have enough AHLOs in Victoria? If not, what's the shortfall? Answers to these questions will dictate whether additional investment is valid.</p>	<p>ICAP should continue to be supported, including AHLOs.</p> <p>Support the role of the Koorie midwife, women will be more comfortable with their own people.</p> <p>Increasing the number of Aboriginal workers in the hospital, including nurses and employment of more AHLOs rather than just one looking after multiple sites.</p> <p>Indigenous trainee positions with proper employment opportunities and clear guidelines (Aboriginal Employment Strategies & Equal Opportunity Act).</p> <p>At least one AHLO should be recruited at each hospital site. Some sites need more than one AHLO.</p>



Influencing willingness to identify	<p>How can we increase the willingness to identify? My reasons for not identifying might be different from yours.</p> <p>Idealistic: Be clear about why identification is important. Demonstrate this by reporting data back to the community, helping them understand where the data goes and why it is useful and how it can benefit the community.</p>	<p>Education for community on what impact identifying will have on them and their community, what's happened to the information and how it influences change.</p> <p>Educating the next generation why the question is asked: More money should be spent on getting the message out in the community. A school program should be funded; the youth can educate mums and dads.</p> <p>Education for the community via the co-op regarding the basics of hospital processes, reinforcement that patients will get the support of an AHLO if they identify, what to do if they experience racism in the hospital and who to talk to about it. Feeling persecuted is a barrier to future identification.</p>
Feedback mechanism	<p>Ongoing scrutiny of the data by the Health Department, hospital by hospital.</p> <p>Provision of data to hospitals, feedback mechanism.</p>	<p>A feedback loop from the State to services is likely to have a positive impact. The health service can perform internal data analysis and benchmarking, however, comparisons State-wide would be beneficial; 'how did we perform?' If we have the data, we should be using it to determine what we are aspiring to and what the numbers mean.</p> <p>Greater validation and an appropriate level of analysis of data at the Department of Health end. This will encourage hospitals to take it more seriously too.</p>
Accountability	<p>Board level accountability.</p> <p>Aboriginal health should be prioritised in each hospital and included in the organisation's vision and business planning.</p>	<p>Hospital resources: Hospitals should be accountable for the WIES loading received and use it to make people comfortable to identify if they are finding it difficult to do so, to acknowledge culture and address equity and the human right to health.</p> <p>You need to get line managers involved for it to happen.</p> <p>The level of Indigenous engagement in hospital-wide policy and procedures. AHLOs should be included as senior management in Closing the Gap partnership talks.</p>
Factors outside the health system	<p>Improving the social determinants of health to help people get to a position where they have good self-esteem. Those with the greatest reticence are those with the greatest fear of the system, low socio-economic status (SES).</p> <p>Encouraging involvement in society and community, improving diet and exercise and thus decreasing chronic illness and increasing health and self-esteem.</p> <p>Long term: changing the mainstream to respect Aboriginal culture.</p> <p>Societal change.</p>	<p>Housing is the number one social factor that should be focused on to consequently improve identification.</p> <p>Higher education: increase the representation of Aboriginal workers in the health system.</p> <p>To close the gap in health, policy should focus on improvements to the social determinants such as housing, employment and education.</p>



National definition	The national definition (constituting self identification, heritage and community recognition) is problematic for birth and death records where identification is provided by a third party (parent, next of kin or other source e.g. hospital record) at the point of registering an event.	N/A
Validation	Policies should focus on how data are used. Record linkage is a useful technique to collect extra information and has the potential to support improvements in identification. Routine validation between datasets is a practical way to assess identification.	N/A
Financial incentives	N/A	Clarify WIES with others in addition to senior management: <ul style="list-style-type: none"> report to the Liaison Officer how WIES dollars are spent—involve those doing the job—AHLOs need to know. Clarify if WIES is supposed to be reinvested to improve services for Aboriginal patients. Financial incentives work but are they the right thing to do? (e.g. \$30 to attend a health checks or a plasma TV raffle, subsidised pharmaceuticals). It's questionable whether these patients follow-up with future appointments or comply with treatments, and it's only likely to be an incentive for low SES that need the money.
Promotional materials	N/A	Promotional materials to encourage Aboriginal people to identify. More posters and Aboriginal artwork around the hospital.

Question 9

Informants were asked to rate the importance of a list of stakeholders in future efforts to improve identification.

All stakeholder groups provided in Table 16 (see next page) were rated of high importance by more than 50% of informants. 'Data collection staff' was rated of high importance

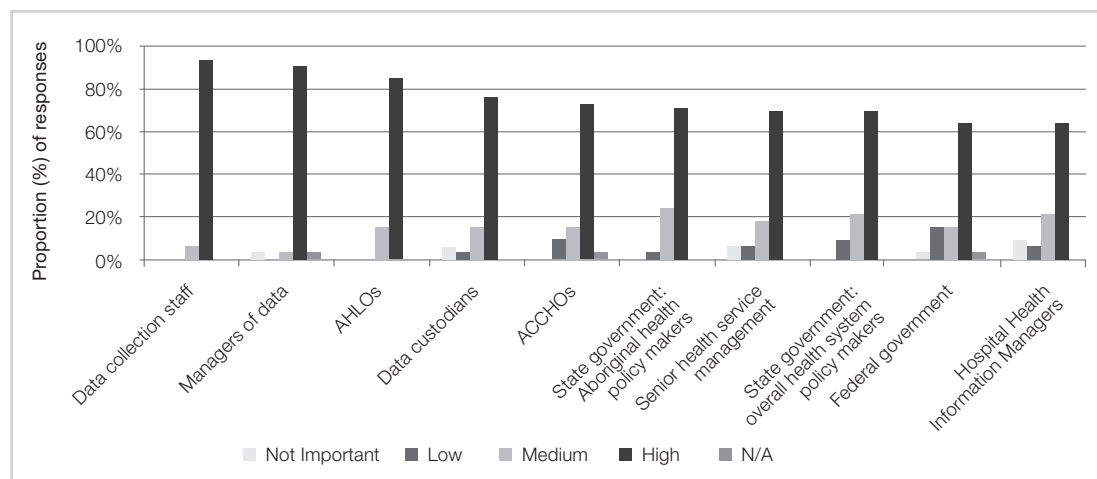
most often (94% of responses), followed by 'managers of data collection staff' (91%) and 'Aboriginal Liaison Officers' (85%). The stakeholders rated of high importance least often were 'hospital Health Information Managers' and the 'Federal government' (equally 64%). Results are summarised in Table 16 and Figure 35 (see next page). All comments are summarised in Appendix C.



Table 16: Summary of responses to Question 9 relating to the importance of stakeholders for engagement in efforts to improve identification in birth, death and hospital data

Key stakeholders	Level of importance					Total responses
	Not important	Low importance	Medium importance	High importance	N/A	
Data collection staff (e.g. hospital registration staff, midwives, funeral directors, death certificate certifying medical practitioners)			2 (6%)	31 (94%)		33 (100%)
Senior health service management (e.g. hospital CEO and Chief Finance Officer)	2 (6%)	2 (6%)	6 (18%)	23 (70%)		33 (100%)
Managers of data collection staff	1 (3%)		1 (3%)	30 (91%)	1 (3%)	33 (100%)
Hospital Health Information Managers	3 (9%)	2 (6%)	7 (21%)	21 (64%)		33 (100%)
Aboriginal Liaison Officers			5 (15%)	28 (85%)		33 (100%)
Aboriginal Community Controlled Organisations		3 (9%)	5 (15%)	24 (73%)	1 (3%)	33 (100%)
Data custodians (State government managers of datasets)	2 (6%)	1 (3%)	5 (15%)	25 (76%)		33 (100%)
State government: Aboriginal health policy makers		1 (3%)	8 (24%)	24 (73%)		33 (100%)
State government: overall health system policy makers		3 (9%)	7 (21%)	23 (70%)		33 (100%)
Federal government	1 (3%)	5 (15%)	5 (15%)	21 (64%)	1 (3%)	33 (100%)

Figure 35: Importance of stakeholders to achieving improved identification as rated by all informants sorted in descending order of high importance (proportion of all responses by initiative)



Question 10

Informants were asked to nominate one initiative to fund, introduce or expand in the future that had the potential to improve Indigenous identification in Victoria. Thematic analysis of responses resulted in six key initiatives/policies. These are represented in Table 17 (below). All responses are included in Appendix C.

Education and training was nominated 11 times by informants as the one initiative they would fund, introduce or expand in the future.

When disaggregated by informant type, the ALO/hospital staff informant group nominated site-based initiatives, such as education and training and AHLO/Aboriginal staff, as the leading initiatives they would elect to fund, introduce or expand.

In comparison, there was a greater diversity of views in the policy/government/academic group. Four initiatives received three votes, one initiative received two votes and one initiative received one vote.

Table 17: Results of thematic analysis of responses to the question 'If you could choose one initiative to fund/introduce/expand to improve identification in Victoria what would it be?'

Initiative/policy (from thematic analysis)	Number of times an initiative was nominated		
	All informants	Informant group	
		ALO/hospital staff	Policy/government/ academic
Education and training	11	8	3
AHLOs and Aboriginal staff	9	6	3
Data analysis and validation	4	1	3
System change	3	2	1
Partnerships	2	0	2
Other	4	1	3
Total	33	18	15



Correlation between data and initiatives (Appendix A)

The annual number of Indigenous-identified public hospital separations and births and annual variations were considered in the context of the State-wide initiatives to improve Indigenous identification. Although one cannot translate the fluctuations in the numbers of Indigenous births and hospital separations as proof of the effectiveness of initiatives in improving/increasing identification, this information does provide a picture of possible correlations (Tables 18–20 and Figures 36–38). Analysis was not performed on Indigenous-identified deaths in the RBDM due to very small numbers (between 49 and 130 deaths annually in years 1994–2010). This did not reflect the number of Indigenous deaths; rather, it reflected the lack of recording of Indigenous status associated with deaths. As such, these data would not be valid indicators of possible effectiveness (or not) of the various initiatives, and were therefore excluded.

In comparison, the VAED, VPDC and RBDM (births) had much greater annual numbers and less annual variation. The VAED identified between 6168 and 13,241 annual Indigenous inpatient separations in the financial years 1997/98 to 2008/09. The VPDC and RBDM reported between 362 and 569 (VPDC), and 452 and 802 (RBDM) births respectively in the calendar years 2000–07.

In considering the VAED data, it is important to note that the data represent the number of hospital separations identified as Indigenous of all ages NOT the number of times an individual has attended (separated from) hospital in a given timeframe. Further, the figures would also include Aboriginal people from outside Victoria attending hospital.

Victorian Admitted Episodes Dataset—public hospital separations

Number of Indigenous-identified hospitalisations in the State-wide VAED increased between all but two years during 1997/98 and 2008/09 (see Table 18 and Figure 36 on next page).

The biggest percentage increase was seen in 2002/03, when Indigenous-identified hospitalisations increased by 14.5%. This was followed by an increase of 11.4% in 2005/06. However, this level of annual increase was not consistently sustained through to 2008/09.

It is difficult to draw conclusions regarding annual fluctuations. Other factors within and outside the health system could have an impact on a staff member's propensity to ask the Indigenous status question and/or for an Indigenous person's willingness to answer it. In addition, increases in numbers of identified patients could have been partially due to initiatives implemented at individual hospitals, which are not included in the Schema of Initiatives (Appendix A), and/or the inclusion/exclusion of unqualified neonates in the data prior to 2003/04 and after 2004/05.

Nonetheless, some important initiatives were introduced in the years prior to increasing Indigenous-identified separations. They included, but were not restricted to, the introduction of the ICAP program in 2004 and its suite of programs such as ICAP posters and calendars; collaboration between VACCHO, DoH and St Vincent's Hospital, with three new ICAP Policy and Project Officer roles, one in each organisation; an increase in the Aboriginal WIES supplement (from 10% to 30%); and an increase in the number of AHLO positions in Victorian public hospitals (from 18 in 2003 to 25 in 2006).

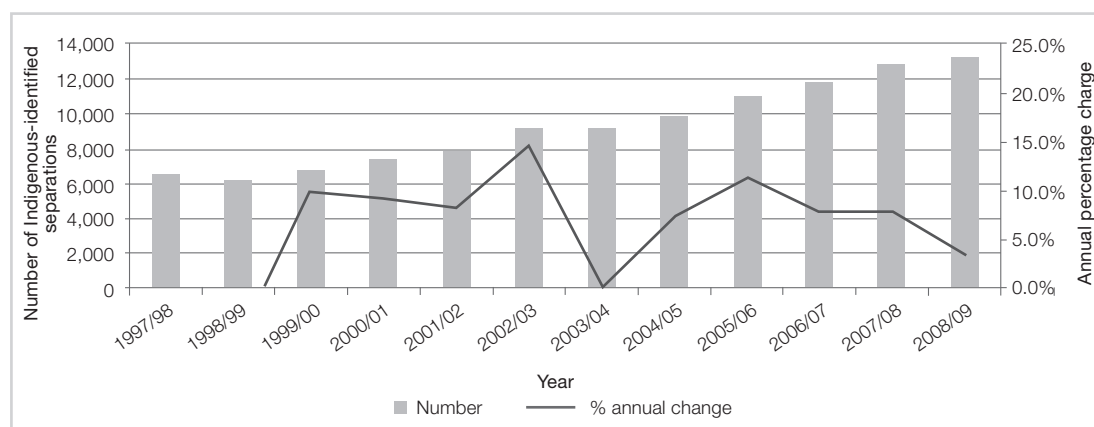


Table 18: Number of Indigenous-identified hospital separations and annual percentage change, VAED, 1997/98–2008/09³⁸

Indigenous-identified hospital separations	Financial year											
	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Number	6,527	6,168	6,772	7,395	8,013	9,176	9,162	9,852	10,978	11,870	12,818	13,241
Proportion annual change		-5.5%	9.8%	9.2%	8.4%	14.5%	-0.2%	7.5%	11.4%	8.1%	8.0%	3.3%

Note: VAED data to 2003/04 from Australian Hospital Statistics (excludes unqualified newborns), while 2004/05 data onwards are from the VAED data cube (includes unqualified newborns).

Figure 36: Number of Indigenous-identified hospital separations by year and annual percentage change, VAED, 1997/98–2008/09³⁹



Note: VAED data to 2003/04 are taken from Australian Hospital Statistics (excludes unqualified newborns), while 2004/05 data onwards are from the VAED data cube (includes unqualified newborns).

Victorian Perinatal Data Collection—births

The number of Indigenous-identified births in the State-wide VPDC increased between six of the seven years investigated. The largest percentage increase was seen between two years: 2004 and 2005 and 2006 and 2007. These were followed by an increase of 17% between 2003 and 2004.

However, levels of annual increase/decrease were inconsistent throughout the period, ranging from 12% and 23% (Table 19 and Figure 37 on next page).

Interestingly, the years of largest annual increase were similar in the VPDC and VAED. The increase was largest between 2004/05 and 2005/06 in the VAED and 2004 and 2005

³⁸ Data provided by the Victorian DoH from Australian Hospital Statistics and VAED data cube.

³⁹ Data provided by the Victorian DoH from Australian Hospital Statistics and VAED data cube.



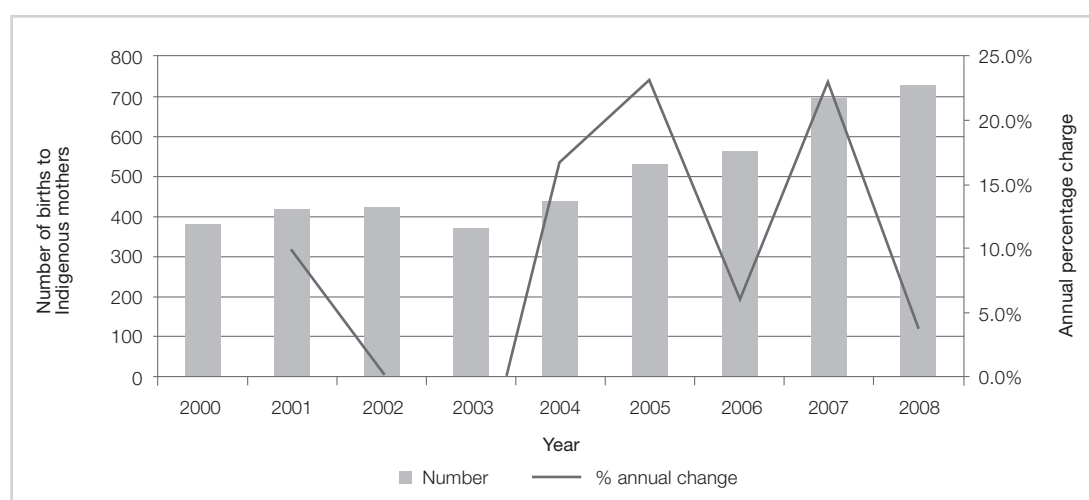
in the VPDC (note: VAED data are reported by financial year whereas VPDC data are reported by calendar year). This could indicate that

numbers of identified persons in both datasets were potentially affected by the hospital-based initiatives under the ICAP program.

Table 19: Number of births to Indigenous-identified mothers and annual percentage change, VPDC, 2000–08⁴⁰

VPDC—births	2000	2001	2002	2003	2004	2005	2006	2007	2008
# births to Indigenous identified mothers	380	419	421	372	435	534	568	698	727
% annual change		10%	0%	-12%	17%	23%	6%	23%	4%

Figure 37: Number of births to Indigenous-identified mothers and annual percentage change, VPDC, 2000–08⁴¹



Registry of Births, Deaths and Marriages—births

The number of Indigenous-identified births in the RBDM increased in four of seven years investigated. The largest percentage increase was seen between 2002 and 2003/04. This was at least partly due to a change in reporting from calendar to financial

years and thus a larger reporting period. The Schema of Initiatives (Appendix A) does not include any policies or initiatives that could explain this 20.1% increase in the number of Aboriginal births between these years. It will be interesting to see the effect of initiatives introduced in 2009 and 2010, when the data are available (see Table 20 and Figure 38 on next page).

⁴⁰ DoH 2011, *Births in Victoria 2007 and 2008*. DoH, Melbourne. p.47.

⁴¹ *ibid.*

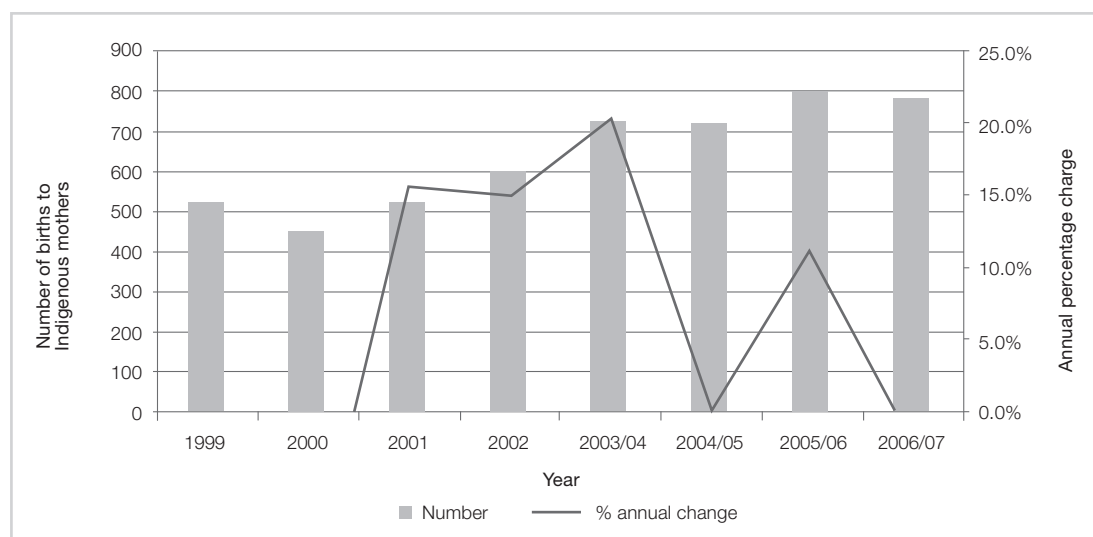


Table 20: Number of Indigenous-identified births and annual percentage change, RBDM, 2000–06⁴²

VPDC—births	2000	2001	2002	2003	2004	2005	2006	2007	2008
# births to Indigenous identified mothers	380	419	421	372	435	534	568	698	727
% annual change		10%	0%	-12%	17%	23%	6%	23%	4%

Note: there was a change in reporting from calendar to financial years in 2003/04.

Figure 38: Number of Indigenous-identified hospital separations by dataset and year and annual percentage change, RBDM, 2000–06⁴³



Note: there was a change in reporting from calendar to financial years in 2003/04.



⁴² DHS 2008, *Koori Health Counts! 2006/07*, DHS, Melbourne. P.47.

⁴³ *ibid*



Discussion

Schema of Initiatives

A literature review and contributions from key informants regarding the history of initiatives implemented to improve Indigenous identification in Victoria have resulted in a valuable record of activity over the past three decades. This resource has particular relevance for AHLOs, health service management, Aboriginal health policy units in State, Territory and Federal governments, and data custodians and colleagues in other States and Territories working towards achieving more accurate Indigenous data in health datasets.

Exclusions

There were many innovative and potentially effective initiatives mentioned by informants that had been introduced at a health service level. These initiatives might have been effective in a local context, but a State-wide impact is questionable. These particular initiatives have been excluded from the Schema.

The Schema does not include developments outside the Victorian health system that may have impacted on the question of Indigenous identity being asked or answered. These include reports and Federal policy such as the *Bringing Them Home* report⁴⁴ or the Northern Territory Intervention in 2007 or the National Apology in 2008. Nor does it include the many

government reports or political speeches over the period that recommended new, expanded and renewed efforts to improve identification.

The final Schema of Initiatives demonstrated that there had been a great deal of activity in this space since the 1980s.

Why is Indigenous identification important?

This study has highlighted the importance of Indigenous identification in population vital statistics collections and in mainstream acute public health service settings. Accurate and complete identification in hospital data is important for ensuring quality, targeted health care for Aboriginal and Torres Strait Islander citizens. Accurate data inform appropriate referrals for Aboriginal patients, provide the empirical evidence to enable appropriate resourcing of hospitals to meet patient demand, and accurately define population/demographic groups in the generation of population health and vital statistics at local, State and national levels. Each of these principles supports the goal of improving health outcomes for Aboriginal Victorians.

These sentiments were echoed in 2011 in a DoH-commissioned evaluation of the ICAP and Koori Mental Health Liaison Officer (KMHLO) program:

⁴⁴ Human Rights and Equal Opportunity Commission 1997, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*, Commonwealth Government, Canberra.

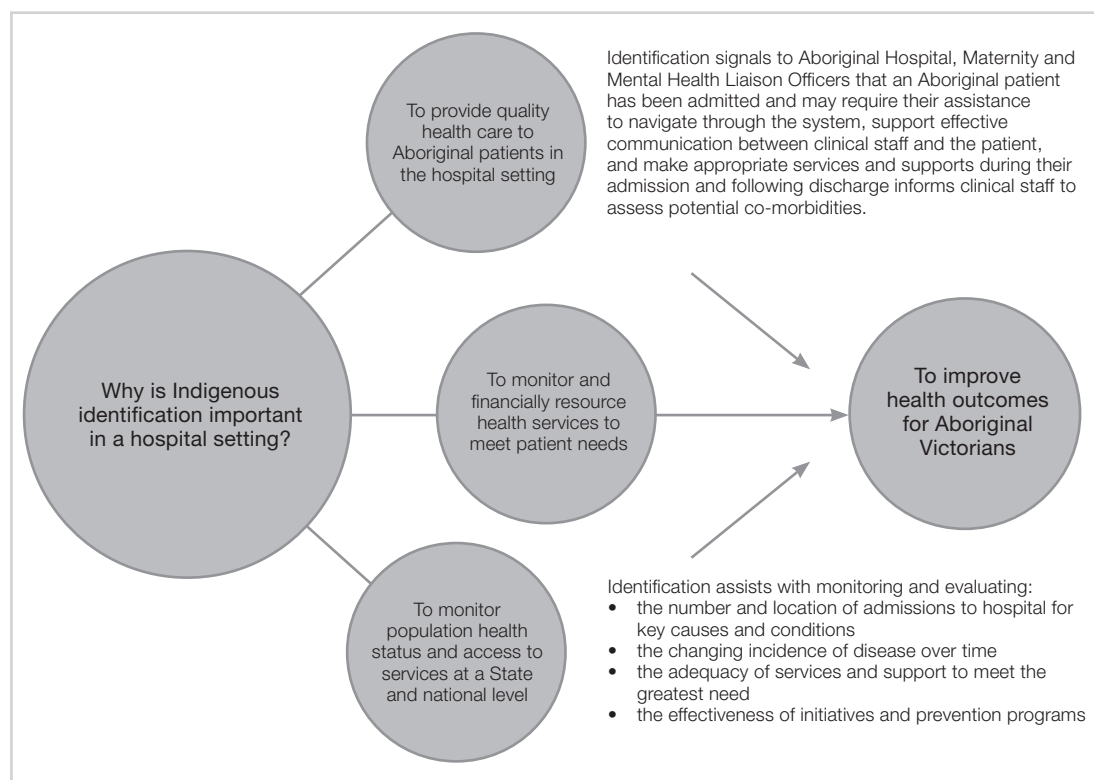


It is essential that good data about Aboriginal service use is available to support planning at a national, State, and local level. Equally as important, is timely identification to ensure culturally responsive care is provided.⁴⁵

The role/importance of Indigenous identification between datasets and settings

In Figure 39 (below) the authors of this report outline the role/importance of accurate Indigenous data in public health care settings.

Figure 39: Pictorial overview of the role/importance of Indigenous identification in improving health outcomes for Aboriginal Victorians in an acute public hospital setting



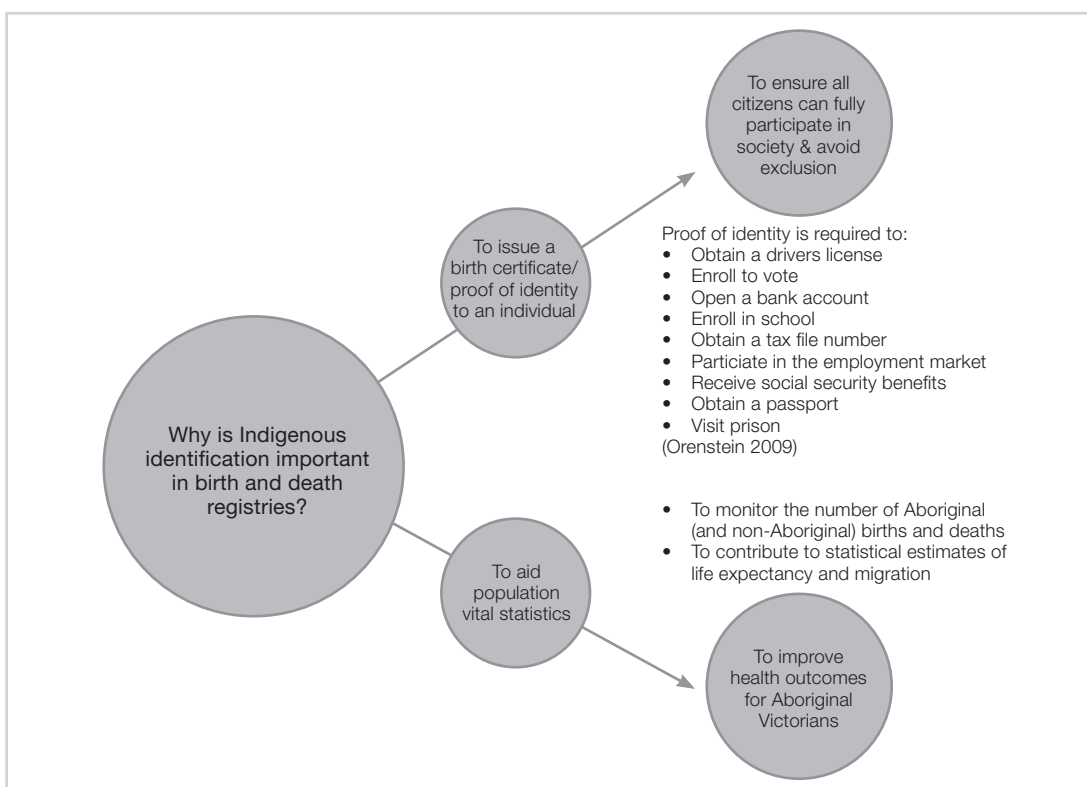
This study has also highlighted the significance of accurate and complete Indigenous identification in the registration of births and deaths. This differs to public health service settings. Identification in birth and death registration data is important to ensure an individual's human right to proof of identity, and thus documents, to enable complete

participation in societal activity. Accurate data also are vital in monitoring population vital statistics and, in the case of births, for providing an accurate denominator to enable the calculation of rates in public health statistics. Figure 40 (see next page) provides a pictorial overview of this two-pronged role of identification in the RBDM.

⁴⁵ DoH 2011, *ICAP and KMHLO Developmental Review: Final Report*, DoH, Melbourne.



Figure 40: Pictorial overview of the role/importance of Indigenous identification in registries of births and deaths⁴⁶



Definition of Indigenous status and methods for collecting Indigenous identity by dataset

One informant raised an interesting distinction between the method for collecting Indigenous identity in birth and death registrations compared to identification for acute hospital admissions and emergency department presentations. Although the national definition applies to all statutory and administrative datasets, for a birth (where the registrant is incapable of self-identifying) the Indigenous status of the parent/s is provided in the VPDC (mother) and RBDM (mother

and father) datasets. Identification of the mother’s Indigeneity helps identify maternal antecedents to birth outcomes.

At the time of death, the Indigenous identity of the deceased is provided by a third party, commonly a parent, spouse or family member. Thus self-identification is not possible and the status of the deceased person’s identity is determined by someone else.

As suggested by one informant in this study, there is potential for a third party’s views and beliefs to influence the identity of

⁴⁶ Adapted from J. Orenstein 2008, ‘The difficulties faced by Aboriginal Victorians in obtaining identification’, *Indigenous Law Bulletin*, vol. 7, no. 8. Accessed 12 January 2012 at: <http://www.austlii.edu.au/au/journals/ILB/2008/37.html>



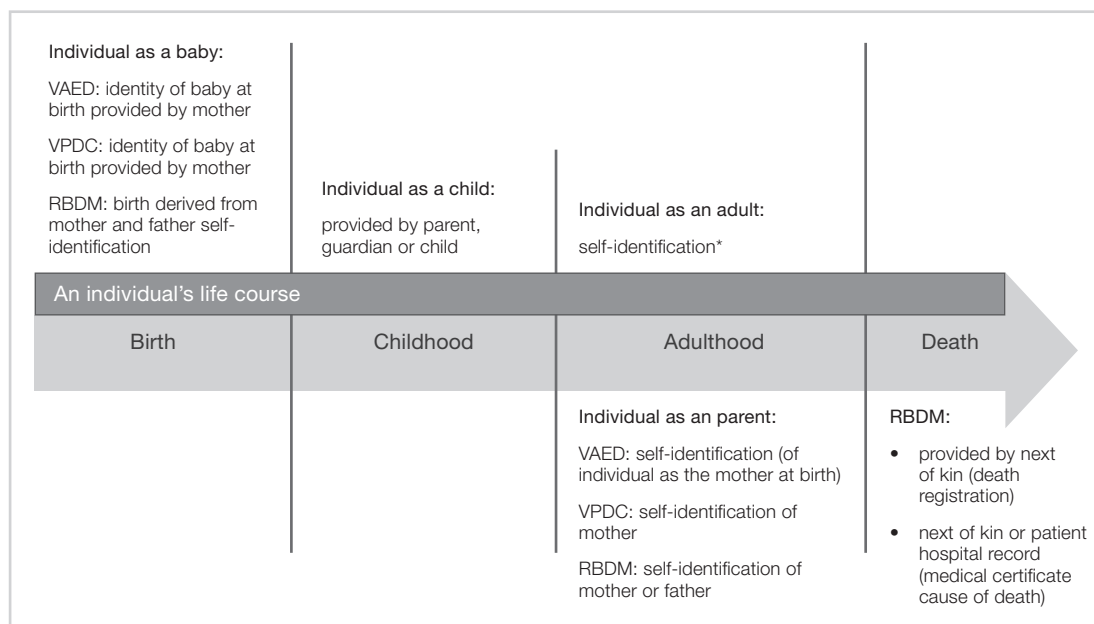
the deceased person in the death record. Such discrepancies between an individual's connection with his or her identity or Indigenous descent and an informant's view may be the result of the informant not being aware of or fully understanding or supporting the individual's identity at the time of death.

As an extension of this discussion, one informant raised a query regarding the legitimacy of the national definition (based on a High Court

judgment in the case of *Commonwealth vs Tasmania* (1983) 46 ALR 625), which includes self-identification as a critical component.

The authors of this report developed Figure 41 (see below) to explore the source of identification over a person's life course. Indigenous identity is only provided by the individual in adulthood in the individual's hospital patient record/s and as an informant in his or her offspring's birth record.

Figure 41: Sources of Indigenous identification of an individual in health datasets over the life course, VPDC, VAED, RBDM



*Providing the individual is conscious, capable and coherent at admission.

Figure 41 (above) highlights a couple of interesting points for discussion. Indigenous identity is collected differently at different stages of the life course (birth, in childhood, adulthood, birth/delivery and death). An individual only truly provides self-identification in health services in adulthood when accessing services and, potentially, at the birth of his or her child.

Therefore, the descent part of the national definition is potentially more applicable at the time of birth and death, and the identity component more relevant at other times of life/adulthood when self-identification applies.

This distinction also provides an argument for the use of matching/linking data at an individual level from multiple data sources to provide a



more accurate and complete picture of the Aboriginal population than data extracted from one data source in isolation. For example, if an individual is identified as non-Aboriginal at birth and death (by a third party), yet chooses to self-identify as an Aboriginal person throughout adulthood when admitted to hospital or registering an infant, matching of these data sources and applying an 'ever-identified' rule would provide a more complete representation of the Aboriginal population.

Data matching/linking also improves the accuracy of data in the instance where a staff member has not asked the Indigenous status question, instead incorrectly assuming Indigenous status from the appearance of the person. Including instances where the question may have been asked and answered correctly can validate inaccurate data.

One limitation of the 'ever-identified' rule is the potential to overestimate the number of Aboriginal births, hospitalisations or deaths due to a misclassification of a non-Aboriginal person as Aboriginal in one dataset. However, the likelihood of a false positive identification is considered less than the chance of a false negative identification. It has been suggested that false positives do occur through either admission clerks or midwives assuming positive Aboriginality without asking the question. However, it was concluded that the number of false positives would be small.⁴⁷ This conclusion has also been confirmed by a study of the quality of Indigenous status data in the NSW Midwives Data Collection.⁴⁸

A further recommendation suggested by a key informant involved the electronic capacity to record a subsequent identity if the subject of the birth registration wishes to do so in adulthood. In 2009, the RBDM implemented the Indigenous Access Project, which enabled adults to sign a statutory declaration to confirm their Aboriginal identity and authorise RBDM to change the identification in birth registrations retrospectively.

Emerging themes from key informant interviews

Barriers to Indigenous identification

Barriers to identification relating to the Indigenous identification question not being asked by staff were rated by informants of greater validity than those relating to an Indigenous person choosing not to declare their status. Results were relatively consistent across both informant groups.

Similarly to results in Question 2.1, results in Question 2.2 indicated that only a small number of informants had been routinely asked about their Indigenous status when accessing health services or registering a birth or death. In addition, very few Aboriginal respondents expressed any issue with self-identifying their Indigenous status when asked. Informants commented, 'I am very proud—I am happy to identify' and 'declaring my Indigenous identification has never been an issue for me—I am who I am'.

These results have relevance for developing policy and initiatives with the view to improving

⁴⁷ T. Owen 1999, *Indigenous Identification in Victorian Birth Records: 1996/97*, DHS, Melbourne.

⁴⁸ L. Taylor & K. Lim 2005, 'Quality of reporting of Aboriginality to the NSW Midwives Data Collection', *NSW Public Health Bulletin*. Vol. 11 No. 1220. p.206.



Indigenous identification, specifically in determining whether focus and investment should be directed towards encouraging the community to self-identify or improving the propensity of staff to ask the question.

When responses were disaggregated by informant group there was good agreement that staff 'guessing identity on appearance', 'not knowing why to ask the question' and 'not asking the question' were highly valid barriers to identification. There was greater variation in views regarding the validity of an Aboriginal person choosing not to declare his or her status on a form or when asked.

There was also some variation between responses provided by hospital-based informants that appeared to correspond with the progress or length of time Aboriginal programs had been effective at their health services. Those informants with well-established and supported programs reported barriers relating to the Indigenous question being asked as having less validity than those with new, less supported programs. This is reflected in some of the variation in responses reported in (Table 5).

Importance of initiatives implemented to improve Indigenous identification

Staff training was mentioned most often by informants as the most effective initiative for improving identification (mentioned 23 times), followed by AHLOs and Aboriginal staff (19), and system enhancements/data improvements (12). It is important to note that although the ICAP program was explicitly mentioned six times, a number of other initiatives, such as AHLOs, Aboriginal artwork,

promotional materials, financial incentives (WIES) and staff training form components of the overarching ICAP program Table 11.

Few informants were aware of the AIHW National Best Practice Guidelines report⁴⁹ when asked in Question 4. Less than 35% of respondents rated the guidelines of high importance, while 18% rated the guidelines of low or no importance Table 10. Although the guidelines received the fewest 'highly important' votes, there was a spread of views in the sample and in each of the disaggregated informant groups. The resources that accompany the guidelines were not listed separately for respondents to rate and therefore there is no way of knowing whether they were aware of their existence or viewed them as important resources for improving identification. Links to these resources accompany the Schema of Initiatives in Appendix A.

Stakeholders for future engagement in efforts to improve Indigenous identification

All stakeholder groups identified in Table 16 were rated of high importance by more than 50% of informants. The table included stakeholders ranging from frontline staff to health service managerial and policy/government personnel and Aboriginal liaison staff. This response confirmed that future efforts to improve Indigenous identification are likely to involve a diverse group and quantum of stakeholders and initiatives, and would require continued commitment and coordination of effort, investment and evaluation across the sector and, indeed, targeted initiatives. The number and breadth of stakeholders is reflected in Figure 42 (see next page).

⁴⁹ AIHW 2010, *National Best Practice Guidelines for Collecting Indigenous Status in Health Data Sets*, Cat. No. IHW 29, AIHW, Canberra.



Figure 42: Overview of stakeholders by dataset

Dataset	Data collection & self-disclosure	Management/folder	Data custodian	Reporting & monitoring
RBDM births	New parents	AHLOs & midwives (birth registration forms provided to parents in hospital)	RBDM Department of Justice	ABS & AIHW
RBDM deaths	Funeral directors Death certifying medical staff: GPs & hospital clinicians	Funeral director associations RBDM Aboriginal Liaison staff	RBDM Department of Justice	ABS & AIHW
VAED VEMD	Hospital registration staff & ward clerks La Trobe University (Health Information Management students)	Hospital CEOs & Chief Financial Officers Managers of registration staff Aboriginal Liaison staff: AHLOs and Aboriginal policy staff Community-controlled health organisations	Health Information, Policy & Standards, DoH	Aboriginal Health Branch, DoH ABS & AIHW
VPDC	Midwives Deakin University (Midwifery students)	Aboriginal Liaison staff: AHLOs and Aboriginal policy staff Midwifery staff, community-controlled health organisations	CCOPMM/ Victorian Perinatal Data Collection Unit (VPDCU), DoH	ABS & AIHW



Although views regarding the importance of some stakeholder groups were relatively consistent (e.g. data collection staff, managers of data collection staff and AHLOs [Table 16]), they were less consistent among other groups such as senior health service management, Health Information Managers, Aboriginal community-controlled organisations, and State and Federal government groups:

- A couple of respondents commented that senior health service managers were ‘important for getting policy pushed through’ and ‘signing off on WIES and accreditation/performance reports’; whereas another commented that ‘senior health service management are not directly involved in the front line so are less important’.
- Some informants thought Health Information Managers (HIMs) were ‘unlikely to be important for future engagement’ and were involved ‘too late in the process’ of identification; others recognised the HIM role in ‘setting up computer systems and forms’, ‘interacting with staff members collecting the data’ and providing invaluable support ‘to improve data collection’.
- A number of informants emphasised that ‘Aboriginal Community Controlled Organisations have little control on what information is collected outside their environment’ yet they ‘are important in promoting understanding in the community’ and promoting ‘word of mouth messages like “make sure you identify in hospital because...”’
- Federal and State government stakeholder groups attracted a mix of comments. On the

one hand respondents recognised their role in ‘driving systems and effective processes’, ‘driving the agenda and funds’ and ensuring ‘ongoing commitment to improved identification and Aboriginal health across government’, and on the other, suggesting ‘data custodians are already engaged’ and that policy and funds are ‘unlikely to translate to service level’.

Although AHLOs were considered to be highly important to improved Indigenous identification, a number of respondents highlighted that their role and responsibility should be reduced. One commented that the ‘emphasis should be taken off AHLOs re identification, [it’s] other [people’s] job’. Another stated that ‘AHLOs are already engaged with the issues’ and therefore did not need further engagement, while another said ‘it’s not the [AHLO’s] role to collect the data but they do play a role in encouraging and supporting staff to ask the question’.

Influences on identification from outside the health system

In Question 7 respondents were asked to consider whether they believed factors outside the health system impacted on an Aboriginal person’s willingness to identify. All respondents answered ‘yes’ to this question (100%). Thematic analysis resulted in 11 common themes (Table 13). The most frequent responses related to an Aboriginal person’s relationship with government and public policies in the past and present, including an individual’s interaction with government agencies, and the effects of past and present policies on community, family and individual experiences, beliefs and identity. Informants believed that both had the ability



to impact on an individual's fear, distrust and stigmatisation.

There were differing views on whether the National Apology to the Stolen Generations was likely to have had a positive impact on an Aboriginal person's willingness to identify. Several informants commented on the need for, or lack of, government action following the Apology, while others commented on the Apology's impact on non-Aboriginal people's thoughts and beliefs.

There were nine references to the role of the media in publicising negative or positive news stories and the potential impact that these have on a person's comfort in identifying, and the media's role in increasing awareness of Indigenous issues, which intersects with press concerning government policy and programs.

The media have a role to play in social stigma and racism, which in turn can contribute to a person's and community's sense of pride or, alternatively, ignite shame and a feeling of dependence. Racism, pride and helplessness and cultural safety were mentioned by informants as factors affecting identification.

Analysis of the number and annual variation in Indigenous-identified births, hospitalisations and deaths, and potential correlation with key initiatives and policies

It is difficult to conclude if specific initiatives can be correlated with changes in the number of Indigenous-identified births and hospitalisations in State-wide datasets over time. This is particularly true for the hospital-based collections where differential increases/decreases in identified patients in individual

sites may or may not be reflected in State-wide datasets, noting the statistics reflect the number of separations over a given time NOT the number of individuals who attended the hospital. Local, site-level analysis of numbers of individuals identifying as Indigenous, in line with the timing of local initiatives implemented, might provide equal or greater insight into the initiatives that have been effective in a specific health service.

In addition, it is difficult to determine whether a change in the number of Indigenous-identified patients or births is due to a real change in hospital separations or the number of patients correctly identified as Indigenous. It is particularly difficult to evaluate the effectiveness of a specific initiative when it has been implemented concurrently with other initiatives. For example, it would be very difficult to separate out the impact of the Aboriginal WIES supplement in health services from other initiatives implemented concurrently as part of the ICAP program.

When data are presented in aggregate in Tables 18–x20 and Figures 36–x38 it is impossible to determine if datasets are identifying the same or different people. There is an opportunity to validate identification by matching data in each of these data sources and using an 'ever-identified' rule of identification. This process is often referred to as data linkage, and is being applied in the VACMS currently being undertaken in Victoria.





Recommendations

This study has demonstrated that a suite of activities is required to tackle the issues associated with under-identification of Indigenous status in health datasets in Victoria and that no one strategy in isolation is sufficient to bridge the data gaps. Based on the views of key informants, the investigators recommend a suite of eight initiatives/policies associated with collecting Indigenous data identifiers:

- formalise a program of data quality training
- maintain and/or expand the number of Aboriginal Liaison/staff roles
- provide systematic reporting back to health services by DoH
- provide clarification of re-investment of WIES loading in Aboriginal programs
- increase evaluation of initiatives and policies implemented to improve Indigenous identification
- continue/introduce system enhancement and data collection of Indigenous identifiers, linkage and projects for Aboriginal staff
- continue to generate communication materials
- accreditation.

Formalise a program of data quality training

Results of this study suggest that staff training in the collection of Indigenous identification

data, distinct from cultural awareness training, would be the most effective initiative for achieving behavioural change in frontline staff and therefore improving the collection of Indigenous identification.

Targeted training in achieving accurate identification was rated of high importance by the largest proportion of informants, and featured in responses to most other questions in the questionnaire. In Questions 8 and 10, education and training for staff was nominated as one of the key initiatives that informants would fund/introduce/expand moving forward.

Although some informants believed cultural respect training was of high importance, others commented that although it was important to create an 'environment and atmosphere that values Aboriginal culture', it is 'most likely to have a low impact on identification'. A number of informants suggested that all staff—'everyone from the top to the cleaner'—regardless of their positions should be trained and made aware through orientation of Aboriginal history and culture. One informant went on to suggest that orientation was a good time to engage with new staff, that 'everyone remembers the people who spoke during orientation'.

Given staff training was so highly regarded by informants in both informant groups, it is interesting to note the somewhat ad hoc, short-term training activities that have taken place since 1980, as identified in the Schema of Initiatives (Appendix A).



Informants provided examples of training currently being delivered by AHLOs, hospital staff and DoH personnel. These examples varied in their timing (orientation, ad hoc or routine), duration, content (data quality, cultural respect and personal stories), audience (select groups of staff or all staff) and responsible facilitator. There were no examples of system-wide, routine training for the hospital sector as a whole.

Three informants also gave examples of education provided by DoH and hospital staff to undergraduate students at Victorian universities, including dental, midwifery, HIMs and medical school students at RMIT, Deakin and La Trobe Universities. Informants recognised that these student sessions raised awareness of issues of identification and cultural awareness, and the link between identification and quality care and reporting. Informants commented:

- it is ‘very important to engage [midwifery students] prior to entering the workforce [as] they may influence existing staff that may otherwise be difficult to influence’
- ‘[The importance of] education provided by the Koori midwife in the form of tutorials for student midwives, graduate midwives and student doctors regarding culture and health, and sensitive cultural care for Aboriginal women. Education is provided in the classroom at Deakin and in the hospital.’

One limitation of existing university-based training, regarding Indigenous identification and cultural awareness, appears to be the informal nature of relationships between educators

and participating universities. To ensure the longevity of these activities, it would be optimal to formalise a training program that included student education. Such arrangements should be imbedded in the training programs, rather than be ‘personality’ dependent.

Views on who was responsible for the delivery of training varied among informants in this study. Some commented that the task of training should be delivered by an external source to the health service, such as DoH, because it reinforced the importance of the topic. Others suggested a partnership between the AHLO and an external person would be optimal. Some believed training should not be delivered or coordinated by existing AHLOs, and one commented that hospitals should be supplied by DoH ‘with a tool kit and training for staff members (see the St Vincent’s Hospital training module—sourced from the ICAP Resources Kit)’.

In the hospital sector, responsibility for training relating to cross-cultural awareness and accurate identification of Indigenous status is vague and seems to be both the responsibility of DoH (and the preceding DHS) and individual hospitals. References to training and specific responsibilities for program delivery are found in department literature, including:

- a 1994 Health and Community Services report⁵⁰ (‘Posters and pamphlets on the reason for asking the question on Aboriginality should be developed by the Koori Health Unit and distributed to all hospitals. Ongoing education and support for hospital admission staff should also be provided’)

⁵⁰ Health and Community Services (H&CS) 1994, *Are You of Aboriginal or Torres Strait Islander Descent? Report on the Implementation of the Mandatory Recording of Aboriginality of Patients Admitted to Hospitals in Victoria*, H&CS, Melbourne.



- the DHS *Aboriginal Services Plan 2008–10*⁵¹ ('Improve the accuracy of identification of Indigenous status in hospital separations through implementing a data quality training program in public hospitals')
- a 2009 DoH report⁵² ('Professional development activities aimed at improving the cultural responsiveness capabilities of health professionals and health care organisations is recognised as a key strategy to improve outcomes for consumers, carers, communities as well as health care providers')
- a 2011 DoH *Closing the Health Gap Implementation Plan*⁵³ ('the department will work with ACCHOs, community health services and local hospitals to provide targeted training on data recording, identifying Indigenous status and improving data collection')
- in 2011, ICAP Key Result Area 2⁵⁴ ('Provide or coordinate cross-cultural training for hospital staff:
 - » Involvement of Aboriginal people in planning, implementation and evaluation
 - » Numbers of training sessions and staff attendance
 - » Clearly articulated policies on the roles of staff and management, protocols and payment rates for internal or external trainers').

Due to the transience of hospital staff, the use of agency staff and the high turnover of admission staff, a comprehensive, routine program of training has the potential for maximum impact and reach. Routine programs should be embedded within orientation programs and at various points during staff career progression, including during undergraduate training and during performance appraisals. Management and Liaison Officers can reinforce the importance of identification. However, staff members need a fundamental understanding of the rationale behind the question to ensure that the question is consistently asked and that they are empowered to respond to any questions they receive from patients/respondents.

One informant commented:

Data collection staff need the support to:

- *understand why the question must be asked and how they are a vital part of the process*
- *how to cope with asking the question of a grieving family*
- *feel confident to ask the question in the context of their work and their knowledge and understanding*
- *ongoing support so if [they] have a bad experience they can talk over it and can learn in a non-threatening environment.*

A number of hospital-based informants in this study emphasised the importance of the link

⁵¹ DHS 2007, *Aboriginal Services Plan 2008–10*, DHS, Melbourne.

⁵² DoH 2009, *Cultural Responsiveness Framework: Guidelines for Victorian Health Services*, DoH, Melbourne. Accessed 17 January 2012 at: <www.health.vic.gov.au/_data/assets/pdf_file/0008/381068/cultural_responsiveness.pdf>.

⁵³ DoH 2011, *Victoria Closing the Health Gap Implementation Plan 2009–13*, DoH, Melbourne.

⁵⁴ DoH 2011, *Quality of Care Reports 2008–09 Review of Victorian Health Service Reporting Against ICAP Key Result Areas*, DoH, Melbourne.



between identification and the provision of quality care. In one hospital, one informant reported that ‘front line staff can be concerned about appearing discriminatory and offensive, particularly if they are unsure why the question needs to be asked’. Another noted, ‘staff are busy but not too busy [to ask the question]. If they are unsure why the question must be asked, they are likely to skip it.’

A formalised training strategy would require centralised coordination given the diversity of requirements of the stakeholders, including different resources, interests and constraints. This approach would:

- provide an opportunity to ensure a consistency in messages
- tailor the training sessions to accommodate the diversity of attendees and meet individual needs
- ensure the development of appropriate instruments to evaluate programs
- ensure a consistent standard of education
- reduce the duplication of effort, thus releasing Aboriginal Liaison staff to dedicate more time to supporting their patients rather than co-ordinating or delivering ad hoc education programs.

This study has reinforced the importance of appropriate training and an ongoing commitment to training. Although the imperative for the latter is evidenced in DoH reports, there were significant gaps in training activity over the past three decades (as evidenced in the Schema of Initiatives) and, further, confusion regarding appropriate responsibility for developing, delivering and resourcing training activities.

It was encouraging that an informant noted:

ICAP was reviewed in 2011 and although there were fundamental improvements to data collection, there is still a long way to go. There is a plan to look at the previous data training pilot, and other opportunities to enhance and deliver for the health service.

Recommendation 1: Develop a coordinated, long-term strategy for staff training in the collection of Indigenous identification data across datasets and sectors targeting frontline registration staff e.g. hospital registration staff, ward clerks, midwives and funeral directors, including the development of a comprehensive evaluation framework at the commencement of this activity.

Maintain and/or expand the number of Aboriginal liaison/staff roles

Various informants stated that the existence or non-existence of an AHLO affected identification in a number of ways. They commented that ‘when a hospital has an AHLO or Aboriginal presence, numbers of Aboriginal patients increase’, while ‘numbers of identified separations appear to lessen in some health services when an AHLO isn’t employed. Without an AHLO, no one is pushing the agenda.’

One informant linked improved identification and birth outcomes in a Victorian hospital to the presence of a Koori midwife, suggesting ‘word of mouth means women now offer their Aboriginal status and ask for the Koori midwife’.



However, several informants suggested that the allocation of one AHLO to a health service posed potential issues with a patient's ability to choose who they connected with. They commented that this could impact on the patient's willingness to identify as Indigenous. Cultural/gender issues and community conflict could affect identification when only one AHLO was available.

Issues regarding the role of AHLOs in improving Indigenous identification in datasets were raised by a number of informants. AHLOs are:

- already over-committed, which can compromise their availability for investing time in initiatives to improve identification
- principally employed to provide assistance to Aboriginal patients, to assist them in navigating through the health system and linking in with appropriate services when discharged
- employed to provide a service to their community, yet they are often expected to undertake policy development and single-handedly deliver all Indigenous programs
- frequently without the required training, skills and remuneration required to take on the additional tasks of improving Indigenous identification.

Recommendation 2: Review the role and distribution of AHLOs in public hospitals across Victoria, particularly their role in improving the collection of Indigenous status information, and increase AHLO staff where appropriate to support the needs of Aboriginal patients.

Provide systematic reporting back to health services by DoH

A number of informants in both informant groups recommended routine, detailed reporting from DoH to senior health service staff and AHLOs regarding the number of Indigenous admissions per site/service, and the allocation of nominal WIES dollars generated from Indigenous-identified patients.

One informant suggested that 'feedback to organisations is critical. [It] really sells the point that health services can't offer a service to a community if they don't identify the community', while another believed that identification was an 'important indicator of Aboriginal people's access to mainstream acute health services and can prompt the need for improved patient identification strategies and inform service planning'.

Several informants mentioned the DHS/DoH-produced *Koori Health Counts!* series of publications, commenting that they were an 'important routine feedback mechanism', 'useful documents which enable the hospital to see itself as part of a bigger picture' and that they are 'good to have in hard copy, helps benchmarking with other hospitals for chronic conditions'.

However, there was a view from one informant that:

analysis provided by the Department does not go deep enough to be useful for an individual service. In addition, services are likely to object to their performance being publically scrutinised in great detail. Health services should [make] use of their own data to perform deeper analysis and research into local issues. Data should be used to start conversations within the health service.



There were also two opposing views regarding the usefulness of reporting back to community organisations regarding hospital data and performance. One informant commented that ‘feedback to the community is highly important and a lot of information seems to be collected. More feedback from the government is needed’; whereas another stated, ‘the co-op is unlikely to be interested in this information’.

Two informants reported that a set of new indicators regarding Aboriginal emergency department presentations, total WIES dollars and Aboriginal WIES were recently added to the PRISM. DoH tables PRISM reports quarterly with health service CEOs and other senior health service executives, including occasionally board members. Informants noted that the report was available to other health service staff on request from their CEO or other executives. DoH has been encouraging greater circulation of these reports by senior staff to those with a responsibility for Aboriginal health, including AHLOs and their managers.

Much of the discussion regarding this recommendation relates to the hospital-based VAED dataset.

With regard to the RBDM datasets, a representative commented that RBDM ‘should not do any community profiling—it is appropriate to give data back in other circumstances’.

Recommendation 3: That DoH continues to actively promote the new indicators regarding Aboriginal health in Program Report for Integrated Service Monitoring (PRISM) reports and the sharing of this information with those with responsibility for Aboriginal health.

That the collection and reporting of these data are evaluated for relevance and application with key stakeholders (e.g. management, AHLOs and DoH stakeholders).

Provide clarification of re-investment of WIES loading in Aboriginal programs

There was a degree of confusion (and frustration) expressed by informants regarding the 30% Aboriginal WIES supplement and the responsibility of health services to reallocate/ reinvest the nominal co-payment in future Indigenous programs and initiatives, including support for Aboriginal Liaison staff.

A DoH publication outlines that the ‘Aboriginal WIES funding is intended to provide greater equity across the health system in recognising the additional costs associated with culturally sensitive and appropriate high quality care for Aboriginal patients’.⁵⁵

Literature associated with the ICAP program states that the 30% Aboriginal WIES supplement:

⁵⁵ DoH 2011, *Koori Health Counts! 2009–10*, DoH, Melbourne.



seeks to encourage health services to build on the work of Aboriginal hospital liaison officers (AHLOs) employed since the early 1980s and to encourage:

- continued employment of AHLOs
- responses proportional to the number of Aboriginal patients identified in health services and the complexity of their health needs
- recognition that ICAP is a whole-of-health-service responsibility (rather than that of AHLOs alone)
- relationships with the Aboriginal community and Aboriginal-based services
- improved access, identification and health care for Aboriginal patients.⁵⁶

The preceding information suggests that hospitals are 'encouraged' to reinvest the nominal WIES in Aboriginal patient support programs and initiatives. However, there is no indication that the hospitals are held to account for the reinvestment of these monies. Many AHLOs in this study commented that they were not informed of the quantum of WIES nominal dollars generated within their health service from Indigenous-identified patients, nor were they aware of any reinvestment targeting continuing or expanding Indigenous-specific programs. This was of concern to many informants.

Comments on this point included (direct quotes):

There is a need for greater transparency and health service accountability around

WIES funding, as indicated in the recent review of the ICAP/KMHLO programs.

WIES incentives should be promoted as data quality improvement rather than Aboriginal funding. Evaluating how much each admission costs provides a clearer picture of how much needs to be invested in Aboriginal health.

WIES is important but also a hindrance. How is the bucket of WIES money being spent?

The WIES loading is capped and WIES dollars are not being translated into an AHLO budget.

Financial incentives are likely to raise awareness, however, the reality of WIES is that it doesn't actually equate to increased dollars. Greater identification may just mean that the health service reaches its WIES cap quicker and the Aboriginal Health Program continues to compete internally for dollars. There is a risk in assuming a WIES loading that identification will result in a greater availability of funds to reinvest in Aboriginal programs, which is not necessarily the case. The WIES loading is really only beneficial to large health services with high volumes of Aboriginal attendances.

The WIES loading is not being used properly by health services.

It is important for AHLOs to have access to funds to further review the issue of identification. It is vital to obtain funds through WIES loading, but it must be ensured that funding is invested in Aboriginal Health and provides some assistance to Aboriginal women (e.g. Taxi vouchers, meal vouchers).

⁵⁶ DoH 2011, *Quality of Care Reports 2008–09 Review of Victorian Health Service Reporting Against ICAP Key Result Areas*, DoH, Melbourne.



Recommendation 4: That DoH provides clarification generally and to AHLOs regarding health services' level of accountability for reporting and re-allocating the nominal Aboriginal WIES supplement generated by identified patients in their health service in Aboriginal initiatives and programs.

Increase evaluation of initiatives and policies implemented to improve Indigenous identification

The final Schema of Initiatives is a rich source of information on initiatives implemented over the past three decades across Victoria to improve Indigenous identification. The Schema, in addition to informant responses to Question 3 (listed in Appendix C), provides a valuable resource for health services and policy makers.

However, informant responses to Question 6 suggested that there have been few evaluations of these initiatives, and/or limited awareness of evaluation activity. Informants mentioned several instances where increases in the numbers of Indigenous-identified patients in a particular health service appeared to coincide with the introduction of an AHLO or local training program. However, many informants were unable to provide any examples of evaluations of programs.

The 2011 DoH evaluation of the ICAP program was the initiative mentioned most often by respondents. Other examples of government validation, reporting and/or evaluation activities included AIHW hospital Indigenous identification audits in 2007 and 2011, the 1992–93, and 2000–01, validations of perinatal data to evaluate improvement

of Indigenous identification, the summary of participant evaluations from the pilot Aboriginal patient identification training sessions held in 2007, and an internal report of the 2009 RBDM Road Show.

Data results reported in the 'Analysis of the number and annual variation in Indigenous-identified births and, hospitalisations and deaths, and potential correlation with key initiatives and policies identified in the Schema of Initiatives' (see Tables 18, 19, 20 and Figures 36, 37, 38) provides a crude examination of the possible correlation between the timing of initiatives and policies implemented to improve identification and the number/annual increases in Indigenous identified hospitalisations and births in the VAED and VPDC. Definitive conclusions regarding the association between the introduction of these initiatives and increases in the number of Indigenous hospital separations and births and deaths would be ill-advised. Local analysis of numbers, as mentioned by informants, may be a more effective use of inpatient data for evaluation purposes. However, there will always be factors independently affecting numbers of admitted patients not linked to identification practices.

Recommendation 5: That future initiatives and policies implemented to improve Indigenous identification include an evaluation strategy to measure efficacy and impact and guide future work/investment locally and at a state and national level.



Continue/introduce system enhancements and data validation

Informants were asked to nominate initiatives that they believed had been effective in improving Indigenous identity and those that would be important to implement in the future. Informants often mentioned system enhancement and data validation techniques. Examples included activities during data collection and data custodianship.

Comments in support of data validation techniques included (direct quotes):

Ongoing scrutiny of the data by the Health Department, hospital by hospital.

Routine validation between datasets is a practical way to assess identification.

Further research aiming to estimate under identification rates.

Capturing subsequent changes in identification over time to reflect an individual's willingness to identify over the life course and get a truer picture of the number of Indigenous people there are in Vic.

Validation of existing systems/data would be easy to implement electronically and could yield a high return.

Funding should focus on data quality analysis and validation of the VAED at the Department of Health end. Greater validation and an appropriate level of analysis of data provided by the Department to hospitals is likely to encourage hospitals to take it more seriously too.

Some techniques, such as system enhancements, can influence and improve processes of identification at the time of

admission/registration. These include built-in system prompts, making the Indigenous status field mandatory to complete, removal of default values, and customised options for recording answers to the question in patient registration systems and electronic birth and death registration systems. Registrant follow up was also mentioned as an activity conducted by the RBDM when information in birth/death registrations is missing or presumed inaccurate.

It is vitally important to ensure that Indigenous identification is correct at the time of admission/registration. However, in addition, informants identified techniques that could be utilised to validate data to improve the quality and consistency of recording Indigenous identification following admission/registration, including (direct quotes):

A mapping exercise was carried out a few years ago by the Health Information Manager at this hospital to target those staff members not asking the Indigenous question (when data is entered on the system, the staff member's name initials are recorded).

Internal audits are important to ensure issues around Indigenous Identification are isolated and identified. Data has been used in this hospital to discover which staff members are not performing according to process guidelines.

Currently, the health service is developing a 'RiskMan' incident follow-through process to pinpoint the staff member responsible for an Aboriginal patient being incorrectly identified as non-Aboriginal because they did not asked the question.

In late 2010 the issue of identification was raised again and various hospital areas were asked to provide a monthly report on how many women had been identified as Aboriginal, with the aim of understanding



what was happening prior to introducing new identification initiatives.

Suggestions for techniques that aim to improve the accuracy, completeness and usefulness of routinely collected data for monitoring, analysis, reporting and health system planning purposes, and for reporting back to data collecting agencies, included (direct quotes):

Continuous validation of VAED hospital data by the Department of Health and follow-up with health services.

Ongoing scrutiny of the data by VAED/ VEMD data custodian and the Koori/ Aboriginal Health Branches.

[The] AHLOC is a classic example of a data validation tool [for the VAED].

Cross-referencing data from the hospital system with Perinatal data.

A notifiable system edit in the VAED: A system flag when country of birth is recorded as other than Australia & Indigenous status is recorded as Indigenous, indicating a potential error.

A further technique for improving the accuracy and completeness of Indigenous status data is data matching/linkage. This technique involves the integration of information believed to relate to the same person, event or members of a family across independent data sources and/ or time. Unfortunately, informants were not given the opportunity to rate the importance of data linkage in Question 3. However, it was mentioned by an informant in Question 10 as a critical initiative for the future: 'Policies should focus on how data are used. Record linkage is a useful technique to collect extra information and has the potential to support improvements in identification.'

Recommendation 6: That health services and data custodians review current processes for recording Indigenous identification in administrative and statutory data and implement best practice processes for data validation of collected data.

Continue to generate communication materials

Over the years, identity posters and pamphlets have been developed by the ABS, AIHW and DoH and distributed widely to hospitals, funeral directors and general practice clinics in an effort to encourage Indigenous identification. These aimed to emphasise the importance of asking and answering the Indigenous status question and communicating how the information is used (see Schema in Appendix A).

In this study informants largely supported the use of promotional materials to 'encourage Indigenous people to identify' and to 'support the collection of accurate data and consequently to provide better services to the Aboriginal community'. One informant believed materials were 'very important not only for identification but also for promoting a culturally-safe environment'. Another suggested that 'the community responds to images they recognise. Artwork creates an inviting environment and posters help break the barriers by acting as a reminder to staff to ask the question.'

The ABS produced identity posters in 2000, which featured Aboriginal faces from the Northern Territory. These were distributed nationally. However, a number of informants commented that they were not appropriate for use in Victoria because they did not feature local Aboriginal and Torres Strait Islander



people and perpetuated the myth that Aboriginal and Torres Strait Islander people could be identified on the basis of their appearance.

A number of informants provided examples and/or suggestions for materials for use in the hospital sector in addition to the standard poster/pamphlet format (direct quotes):

Social marketing is important for achieving accurate identification (e.g. DVDs or other paraphernalia to promote health services, the care and services provided. This may be helpful for community understanding and improving negative perceptions).

The hospital prints a 'Quality of care' report in the district newspaper, which includes a section on the ICAP program at the hospital.

Patient care books include information on the AHLO/services, and an insert is included for the trainee doctors.

Local hospital circulars [for] generating interest.

Quality of care sessions/materials: Articles are prepared throughout the year to raise awareness of Indigenous health outcomes and the importance of providing quality care.

In the case of death registrations, an informant provided a copy of a circular sent to funeral directors Association members by the RBDM titled 'Funeral Director's Express', which in at least one edition provided guidance to funeral directors on why and how to ask a deceased person's next of kin about his or her Indigenous status.

Recommendation 7: That government agencies and health services continue to develop point-of-identification posters and pamphlets to emphasise the importance of asking and answering the Indigenous status question and how the information is used.

Accreditation

Accreditation was mentioned by informants as a 'valuable tool' for improving Indigenous identification and holding institutions accountable for identification and the WIES loading received. Suggestions took a number of different forms, including Indigenous identification information/education in clinical accreditation for medical personnel in public hospitals and general practice, and accreditation for funeral directors and for hospitals via reporting in hospital quality of care reports/programs.

One example provided by informants was the existing hospital Quality of Care reporting. As a condition of receipt of the WIES loading, hospitals are required to report against four ICAP key result areas in their annual Quality of Care reports to DoH: 'Prior to the 2007–08 review of the quality of care reports, there were no formal, comprehensive reviews of reporting against the ICAP [key result areas]'.⁵⁷ The Quality of Care reporting is now the official source of reporting against ICAP key result areas for health services. This initiative followed recommendations made in the 2004 Aboriginal and Torres Strait Islander Accreditation Project report.⁵⁸

⁵⁷ DoH 2011, *Quality of Care Reports 2008–09 Review of Victorian Health Service Reporting Against ICAP Key Result Areas*, DoH, Melbourne.

⁵⁸ VicHealth Koori Health Research and Community Development Unit 2004, *VicHealth Koori Health Research and Community Development Unit: Summary of Findings from Hospital Case Studies & Recommendations for Accreditation*, VKHRCDU, Melbourne.



Recommendation 8: That DoH continues to hold health services accountable for the receipt of the Aboriginal WIES supplement through reporting in Quality of Care reports. And that opportunities continue to be explored for linking clinical accreditation with demonstrated knowledge and recording of accurate Indigenous identification

Limitations

Although the response rate from informants to the invitation to participate was very good, the final sample of informants had much greater knowledge of hospital-based datasets rather than the RBDM, and to a lesser degree the VPDC. It was more difficult to engage informants with specialist knowledge of the RBDM and VPDC datasets. This could partly be due to staff turnover and the fact that the RBDM does not employ client-facing data collectors for birth and death registrations. Efforts have been taken to report results for the RBDM datasets separately. However, findings arising from this study will be more applicable to the hospital-based datasets than those of the RBDM or VPDC.

In addition, investigators experienced difficulty engaging health service CEOs. Of those invited to participate, all either delegated their participation to other health service personnel or were unable to respond. Those personnel who were delegated to participate had a good knowledge of the issues, but the absence of views of CEOs does constitute a limitation.

In addition, there was some difficulty concluding and reporting which responses related to which datasets. Although informants were asked in Question 1 to nominate the

datasets their knowledge related to, there was a sense during interviews that an informant's responses related to one of the several datasets they had nominated. The study design did not include the capacity to record which comment related to which dataset. It would have been beneficial to have had the capacity to disaggregate responses by dataset to explore informants' views according to a specific dataset. As informants indicated that their knowledge related to up to four datasets, to relate responses to each dataset would have made the questionnaire/interview extremely dense and time consuming.

Instead, investigators reported results for the whole sample and then disaggregated responses by informant group. These groups were devised by the authors during analysis based on their knowledge of informants' current and previous roles and organisation/s. The allocation of informants to each group was based on consideration of their discipline/s. A number of informants could have easily been represented in both groups.

Furthermore, responses to questions were often specific to an informant's experience in a particular health service, and therefore not necessarily representative of experiences in health services across the State. This was particularly apparent for hospital-based personnel responding to Question 2.1, where informants were asked to nominate the validity of previously published barriers to identification. Where one informant rated a barrier of low validity in relation to identification practices in his or her individual health service, another rated the barrier of high validity due to the immaturity of programs and services in a different health service.



The initial focus of this study was to explore initiatives implemented to improve identification in datasets involved in the VACMS. This excluded general practice and Victorian private hospital datasets. General Practitioners have influence on the identification of deceased persons registered in the RBDM death dataset by certifying Medical Certificates of Cause of Death,

including nominating Indigenous status. Some General Practitioners certifying the death of a patient could have a very good knowledge of the deceased and his or her family, perhaps more so than a funeral director completing the Death Registration Statement that also contributes to the death record. Therefore, any future iteration of this work would benefit from involving general practice in the study.

Conclusion

Demographic data in administrative and statutory health datasets help identify individuals and populations at risk of ill health, such as the elderly, refugees, Indigenous peoples, males/females etc. Accurate and complete identification of Aboriginal inpatients, mothers and babies, and deceased persons is important today for the same reasons it was important in the early 1980s when the Health Commission of Victoria attempted to 'establish baseline statistics on the health status of Aborigines in Victoria' in order to 'accurately determine the areas of greatest need in Aboriginal health' and 'assess the effectiveness of service delivery'⁵⁹ Today, these data are used to provide appropriate care for Aboriginal Victorians, guide program development and investment, and review State and Federal government performance against indicators in key policies/frameworks such as the *National Health*

*Performance Framework*⁶⁰, *COAG Closing the Gap Reform*⁶¹ and *Victorian Indigenous Affairs Framework*⁶² targets and indicators.

Analysis of the views of key informants in this study informed the development of eight recommendations with the aim of informing health service decision making and planning and policy development. Investigators hope that these will be reviewed by health service and government stakeholders to ensure continued improvements in the identification of Aboriginal patients and persons, and thus, quality healthcare and population health.

Improving the accuracy and completeness of Indigenous identifiers in Victorian statutory and administrative data collections will enable more truthful reporting on the progress of 'closing the gap' in health disparities for Aboriginal people.

⁵⁹ Health Commission of Victoria (HCV) 1984, 'Appointment of Aboriginal Health Statistics Officer', Circular No. 30/1984, HCV, Melbourne.

⁶⁰ Australian Institute of Health and Welfare 2009, 'National Health Performance Framework 2009'. Accessed 12 January 2012 at: <http://meteor.aihw.gov.au/content/index.phtml/itemId/435314>

⁶¹ 'National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan', Victoria. Accessed 12 January 2012 at: www.Federalfinancialrelations.gov.au/content/national_partnership_agreements/indigenous/closing_the_gap_health_outcomes/VIC.pdf.

⁶² Department of Planning and Community Development, 'Victorian Indigenous Affairs Framework 2010-2013'. Accessed 19 January 2012 at: http://www.dpcd.vic.gov.au/_data/assets/pdf_file/0009/49986/VIAF_2010_2013_FINAL.pdf



Appendix A:

Final Schema of Initiatives Implemented to Improve Indigenous Identification in Victorian Health Datasets (Including links to resources and attachments)

Victorian Admitted Episodes Dataset (public hospital separations)

Victorian Admitted Episodes Dataset						
1980	1981	1982	1983	1984	1985	
<p>The Working Party into Aboriginal Health provided a report with four main recommendations including: the establishment of the Aboriginal Hospital Liaison Officer (AHLO) Scheme with 43 positions recommended State-wide, and a State Aboriginal Liaison Unit (1)</p>	<p>The Working Party into Aboriginal Health provided a report with four main recommendations including: the establishment of the Aboriginal Hospital Liaison Officer (AHLO) Scheme with 43 positions recommended State-wide, and a State Aboriginal Liaison Unit (1)</p>	<p>Establishment of the Health Department Aboriginal Liaison Unit under an Aboriginal Coordinator, and the establishment of the AHLO program with the transfer of 10 Aboriginal Health Aid positions and addition of 6 new positions (note: 14 Aboriginal Health Aids were first employed in 1976) (1)</p>	<p>Official definition of an Aboriginal and Torres Strait Islander person resulting from the High Court decision in Commonwealth vs Tas(2)</p> <p>An informal AHLO collection commenced in 1982/83</p> <p>Two additional AHLOs employed (Mercy Maternity & Assistant Coordinator/Locum)</p>	<p>Appointment of Gavin Jennings, the first Aboriginal Health Statistics Officer, Health Commission of Victoria, tasked with promoting the collection of information on Aboriginal births, deaths and morbidity from government, health institutions and community (3)</p> <p>Establishment of the Aboriginal Health Resources Consultative Group to advise the Minister for Health on matters relating to Aboriginal Health. The group strongly supported the need for collection of baseline data (4)</p> <p>One additional AHLO employed (Metro Alcohol & Drugs)</p>	<p>1986/87–1992/93: Introduction of Code 08 in the 'Country of birth' variable in the VAED distinguishing Aboriginal and Torres Strait Islander identity</p> <p>Two additional AHLOs employed (Bendigo & Ballarat)</p>	<p>1987</p> <p>Commonwealth funding no longer available for the Aboriginal Health Statistics Officer, therefore resigned</p> <p>First internal review of the Health Department Aboriginal Health Unit, name changed to Koorie Health Program Development Unit</p>

Victorian Admitted Episodes Dataset (continued)

1988	1989	1990	1991	1992	1993	1994	1995
AHLO data collection formalised at DHS incl. Aboriginal admissions & births	Early-mid 1990's: Best Practice Awards awarded to hospitals to raise awareness and encourage identification				<p>Identification of Indigenous status in the VAED for public hospitals made mandatory</p> <p>Health & Community Services hospital circular 28/1993: Recording of Aboriginality (5)</p> <p>1993/94–1998/99: Introduction of an 'Aboriginality' variable with Yes or No responses in the VAED</p>	<p>Standardisation of the question 'Are you of Aboriginal or Torres Strait Islander origin?' by ABS</p> <p>Are you of Aboriginal or Torres Strait Islander Descent? Report on the implementation of the mandatory recording of Aboriginality of patients admitted to hospitals in Victoria' report, Public Health Branch, H&CS</p>	



Victorian Admitted Episodes Dataset (continued)							
1996	1997	1998	1999	2000	2001	2002	2003
Victorian Aboriginal Community Controlled Health Organisation established	1997/98: Introduction of Code 02 in the 'Aboriginality' variable in the VAED to distinguish Torres Strait Islander status from Aboriginal status	Late 1990's/ early 2000's: ABS identity posters and pamphlets distributed to hospitals	Introduction of the ATSI WIES 10% Co-payment to the VAED for Indigenous identified patients 1999/00: Introduction of an 'Indigenous status' variable in the VAED according to the National Health Data Dictionary (NHDD) V6 (four responses: No, Yes Aboriginal, Yes Torres Strait Islander, and Yes both) ABS published Standards for statistics on Cultural and Language diversity (6)	Linking of perinatal, VAED and RBDM births data in a study by DHS (results not published) ABS identity posters and pamphlets developed in the NT and distributed nationally to funeral directors, General Practitioners and hospital staff Patient Record System update to make the question of Indigenous status a mandatory field in the VAED		2002–2011: adhoc DHS/DoH hospital registration staff training across the State 18 hospitals employing AHLOs.	18 hospitals employing AHLOs. VACCHO ICAP Officer role introduced raising awareness among the VACCHO membership & community

Victorian Admitted Episodes Dataset (continued)							
2004	2005	2006	2007	2008	2009	2010	2011
2002–2011: adhoc DHS/DoH hospital registration staff training across the State							
<p>VicHealth Koori Health Research and Community Development Unit report: Summary of Findings from Hospital Case Studies & Recommendations for Accreditation</p> <p>'Launch of ICAP program including:</p> <p>2004/05 ATSI WIES 30% Co-payment loading, and establishment of three ICAP Project/Policy Officer roles based at VACCHO, DHS and at St Vincent's Health (7)"</p> <p>DHS Hospital circular 12/2004 Recording of Aboriginal status on death certificates (9)</p> <p>DHS leaflet for hospitals: Principles of recording Aboriginal status in Victoria</p>	<p>2005/06: disaggregation of unknown response into 'Question unable to be asked' & 'patient refused to answer' in the VAED</p> <p>Changes to wording in hospital Quality of Care Reports to increase health service accountability for Aboriginal programs and identification</p> <p>'2005–2007: Removal of default value 'not Indigenous' and update to Indigenous Status as a mandatory field in a number of hospitals'</p>	<p>25 hospitals employing AHLOs in 2005/06</p> <p>ICAP calendars and posters produced by DHS ICAP Officers featuring local community members</p> <p>ABS identity posters updated to include a variety of Aboriginal faces</p> <p>Introduction of 'question unable to be asked' & 'patient refused to answer' options in the VAED, which highlighted hospitals that were using 'not stated' or 'non-Indigenous' as a default</p>	<p>DHS data quality training pilot for registration staff conducted in two large public hospitals (results not published)</p> <p>25 hospitals employing AHLOs in 2006/07</p> <p>Vic hospital data audit conducted by DHS on behalf of AIHW as part of a national project. Report published by AIHW in 2007/08 whereby Vic hospital data was accepted by AIHW for future publication</p>	<p>2008/09: Change to VAED codeset meant that codes in each period were not the same, which may affect the quality of data</p>	<p>Ngarngadjii Listen/Understand! ICAP Resource kit published including an Ask the question handout and PowerPoint presentation (10)</p> <p>'Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP): Information for health services in receipt of the 30% Aboriginal WIES supplement' published by DoH (7)"</p> <p>Two versions of ABS pamphlets and posters distributed: 1) to assist people asking the identity question, and 2) assisting people answering the identity question (11)</p> <p>2009 ICAP Conference attended by AHLOs, their managers, CEOs, allied health practitioners, social workers, and ICAP executive sponsors. Conference included a focus on identification</p>	<p>'AIHW Best practice guidelines and resources developed and distributed:</p> <ul style="list-style-type: none"> National best practice guidelines for collecting Indigenous status in health data sets One simple question brochure One simple question poster Staff training tips Staff knowledge training tool Patient fact sheet (12) <p>Aboriginal and Torres Strait Islander Patient Quality Improvement Toolkit for Hospital Staff published (Improving the Culture of Hospitals Project) (13)</p>	<p>Vic hospital data audit conducted by DHS on behalf of AIHW as part of a national project (14)</p> <p><i>Koori Health Counts 2009–10</i> published (15)</p> <p>Introduction of Aboriginal indicators to EQUiP Accreditation framework</p> <p>Results of ICAP program evaluation released (16)</p> <p>Indigenous admission and WIES data items added to PRISM reporting by DoH to health service executives</p> <p>Quality of care reports 2008–09: Review of Victorian health service reporting against ICAP key result areas report (17)</p>



Victorian Perinatal Data Collection (continued)							
1996	1997	1998	1999	2000	2001	2002	2003
Koori pilot birthing services project (Mornington Peninsula & West Gippsland hospitals)	1997: Child Protection Services (CPS) initiated the 'I'm an Aboriginal Dad' program (with the Mercy Hospital) to support Aboriginal fathers by helping them to engage with the community and approach Koori services on offer	Births in Victoria 1992–1996 report with analysis by Aboriginality published by CCOPMM (18)	Births in Victoria 1996–1998 report with analysis by Aboriginality published by CCOPMM (18) 'Perinatal birth statistics reported in the DHS report <i>Koori Health Counts!</i> (1996 birth data) and cross-referenced with RBDM, VAED & AHLOC data' Coding standards for responses to Indigenous status question published in the ABS Standards for Statistics on Cultural and Language Diversity (6)	Linking of midwives data, hospital data and births registry data in a study by DHS (results not published)	Births in Victoria 1999–2000 report with analysis by Aboriginality published by CCOPMM (18)		Births in Victoria 2001–2002 report with analysis by Indigenous status published by CCOPMM (18) Mercy Hospital for Women report: Data quality study on patient information (Aboriginal & Torres Strait Islander Status) (20)
Victorian Aboriginal Community Controlled Health Organisation established							





Victorian Perinatal Data Collection (continued)							
2004	2005	2006	2007	2008	2009	2010	2011
	Births in Victoria 2003–2004 report with analysis by Indigenous status published by CCOPMM (18)			Ongoing presentations for midwifery students at Victorian universities provided by VPDC staff regarding asking the question and cultural factors relating to birth.			
				Presentations and pamphlets provided to midwives throughout Victoria as part of information sessions regarding changes to the Perinatal Data Collection effective 1 Jan 2009 including the introduction of a variable to record the Indigenous status of the baby	Introduction of a variable to record the Indigenous status of the baby in the VPDC from 1 Jan.		Births in Victoria 2007–2008 report with analysis by Indigenous status published by CCOPMM (22)
				Births in Victoria 2005–2006 report with analysis by Indigenous status published by CCOPMM (21)			



Victorian Perinatal Data Collection (continued)							
2004	2005	2006	2007	2008	2009	2010	2011
			Aboriginal Heritage Commemorative Birth Certificates introduced (23)		RBDM Indigenous Access Project and Fund introduced including: Aboriginal Community Information Sessions conducted in 16 rural locations (24) Two versions of ABS pamphlets and posters distributed: 1) to assist people asking the identity question, and 2) assisting people answering the identity question (11)	Wording of the standard question modified in the birth registration form to 'Australian Aboriginal or Torres Strait Islander origin' March 2010–June 2011: Department of Justice Service Centres established providing BDM 'outlets' in 13 rural locations	

Registry of Births, Deaths and Marriages (deaths)

Registry of Births, Deaths and Marriages (deaths)						
1980	1981	1982	1983	1984	1985	1986
			Official definition of an Aboriginal and Torres Strait Islander person resulting from the High Court decision in <i>Commonwealth vs Tas</i> . ⁽²⁾	Appointment of Gavin Jennings, the first Aboriginal Health Statistics Officer, Health Commission of Victoria, tasked with promoting the collection of information on Aboriginal births, deaths and morbidity from government, health institutions and community. ⁽³⁾	Indigenous status question introduced to Medical Certificate of Perinatal Death	'Indigenous status question introduced to death notification form and Medical Certificate of Cause of Death'
						1987
Registry of Births, Deaths and Marriages (deaths) (continued)						
1988	1989	1990	1991	1992	1993	1994
		Early 1990s: RBDM commenced relationships with the Funeral Directors Association, Vic chapter				ABS standardisation of the question 'Are you of Aboriginal or Torres Strait Islander origin?'
						1995
Registry of Births, Deaths and Marriages (deaths) (continued)						
1996	1997	1998	1999	2000	2001	2002
				ABS identity posters and pamphlets developed in the NT and distributed nationally to funeral directors, General Practitioners and hospital staff		
						2003



Registry of Births, Deaths and Marriages (deaths) (continued)							
2004	2005	2006	2007	2008	2009	2010	2011
DHS Hospital circular 12/2004 Recording of Aboriginal status on death certificates (9)		ABS identity posters were updates to include a variety of Aboriginal faces		<p>ABS Information Paper: Cause of Death Certification Australia 2008 (25)</p> <p>ABS Information Paper: Census Data Enhancement – Indigenous Mortality Quality Study, 2006–07 (26)</p>	<p>Indigenous status question modified on online death registration statement for funeral directors – no longer able to record 'not known'</p> <p>RBDM Stakeholder engagement program introduced</p> <p>Two versions of ABS pamphlets and posters distributed: 1) to assist people asking the identity question, and 2) assisting people answering the identity question (11)</p>	Two funeral director meetings with RBDM in 2010 included Indigenous identification on the agenda	<p>Jun 2011: RBDM presentation to the Australian funeral directors Association (Vic Chapter) annual conference including the requirement for Indigenous identification</p> <p>RBDM email newsletter distributed to Funeral Directors titled Funeral Directors Express which included a section 'How can I contribute to the accurate recording of Indigenous deaths?'</p>



Links and attachments referenced in the final Schema of Initiatives

The Schema of Initiatives was devised through a combination of research and information provided by key informants. Where available, web links and attachments have been provided below to correspond with initiatives and policies listed in the schema.

1. Attached (page 110): *Draft History of the Koori Health Program Development Unit*.
 2. Link: AIHW n.d., METeOR, AIHW Metadata Online Registry, 'Person—Indigenous status, code N', <<http://meteor.aihw.gov.au/content/index.phtml/itemId/291036>>.
 3. Attached (page 113): HCV 1984, 'Appointment of Aboriginal Health Statistics Officer', Circular 30/1984, HCV, Melbourne.
 4. Attached (page 114): HCV 1984, 'Identification of Aboriginal and Torres Strait Islander Patients on Hospital Records', Circular 6/1984, HCV, Melbourne.
 5. Link: Health and Community Services 1993, 'Recording of Aboriginality, Country of Birth, and Patient's Usual Residence on the Victorian Inpatient Minimum Database', Circular No. 28/1993, <<http://health.vic.gov.au/hospitalcirculars/circ93/circ28-1993.pdf>>.
 6. Link: ABS 1999, '1289.0—Standards for statistics on cultural and language diversities, 1999', <www.abs.gov.au/AUSSTATS/abs@.nsf/DirClassManualsbyTopic/79FAB04272992D54CA25697E0018FEBD?OpenDocument>.
 7. Link: State Government Victoria 2009, *Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP): Information for Health Services in Receipt of the 30% Aboriginal WIES Supplement*, DoH, Melbourne, <[http://docs.health.vic.gov.au/docs/doc/D4CF768FAB6AB4FCCA257879000A3D04/\\$FILE/ICAP%20Guidelines.pdf](http://docs.health.vic.gov.au/docs/doc/D4CF768FAB6AB4FCCA257879000A3D04/$FILE/ICAP%20Guidelines.pdf)>.
 8. Link: VicHealth Koori Health Research and Community Development Unit 2004, *VicHealth Koori Health Research and Community Development Unit: Summary of Findings from Hospital Case Studies & Recommendations for Accreditation*, VKHRCDU, Melbourne, <www.onemda.unimelb.edu.au/docs/CR4-Hospitalaccred.pdf>.
 9. Link: DoH 2004, Hospital Circulars, 'Hospital Circular 12/2004' (subject: Recording of Aboriginal status on death certificates), <<http://health.vic.gov.au/hospitalcirculars/circ04/circ1204.htm>>.
 10. Link: S. Posenelli, A. Clarke, S. Ewen & N. Waddell 2009, 'Ngarngadjil! Listen/Understand! Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) Resource Kit', DoH, Melbourne, <www.health.vic.gov.au/__data/assets/pdf_file/0008/423647/icap_resource_kit2.pdf>.
 11. Link: ABS posters:
'Aboriginal? Torres Strait Islander? Do you know?'
<<http://www.shiregps.org.au/documents/200608Identificationofpatients.pdf>>
'Are you... Aboriginal Torres Strait Islander?'
- Poster: <http://www.shiregps.org.au/documents/Indigenous%20A3%20Poster_new%202009.pdf>
- Brochure: <<http://www.shiregps.org.au/documents/Indigenous%20general%20DL%20brochure%20new%202009.pdf>>
12. Links: AIHW National Best Practice Guidelines (report and additional resources), <www.aihw.gov.au/guidelines-for-collecting-indigenous-status/>:
 - a. AIHW 2010, National Best Practice Guidelines for Collecting Indigenous Status in Health Data Sets, Cat. No. IHW 29, AIHW, Canberra



- b. 'One simple question could help you close the gap...' (brochure)
 - c. 'One simple question could help close the gap...' (poster)
 - d. 'Are you of Aboriginal or Torres Strait Islander origin?' (patient fact sheet)
 - e. 'Staff training tips' (handout)
 - f. 'Staff knowledge training tool for Indigenous identification' (training tool).
13. Link: Cooperative Research Centre for Aboriginal Health, Aboriginal Health Council of South Australia, La Trobe University & Onemda VicHealth Koori Health Unit 2010, 'Aboriginal and Torres Strait Islander Patient Quality Improvement Toolkit for Hospital Staff (Improving the Culture of Hospitals Project)', <www.svhm.org.au/aboutus/community/ICHPToolkit/Pages/toolkit.aspx>
 14. Link: AIHW 2010, *Indigenous Identification in Hospital Separations Data: Quality Report (including results of the audit of the quality of Indigenous identification in hospital separations data)*, Health Services Series No. 35, Cat. No. HSE 85, AIHW, Canberra, <www.aihw.gov.au/publication-detail/?id=6442468330>.
 15. Link: DoH 2011, *Koori Health Counts! Victorian Aboriginal Hospital Data 2009–10*, DoH, Melbourne, <[http://docs.health.vic.gov.au/docs/doc/7296E8A6DEF87671CA2579120082FD68/\\$FILE/1109027_koori_health_counts_7.pdf](http://docs.health.vic.gov.au/docs/doc/7296E8A6DEF87671CA2579120082FD68/$FILE/1109027_koori_health_counts_7.pdf)>.
 16. Link: DoH 2011, *ICAP and KMHLO Developmental Review Final Report* (available on request from the Aboriginal Health Branch), <www.health.vic.gov.au/aboriginalhealth/programs/improving_care.htm>.
 17. Link: DoH 2011, *Quality of Care Reports 2008–09: Review of Victorian Health Service Reporting against ICAP Key Result Areas*, DoH, Melbourne, <[http://docs.health.vic.gov.au/docs/doc/C7CCD1B8902FCCC2CA25785D001D9D35/\\$FILE/1103012_ICAP_quality_care_WEB.pdf](http://docs.health.vic.gov.au/docs/doc/C7CCD1B8902FCCC2CA25785D001D9D35/$FILE/1103012_ICAP_quality_care_WEB.pdf)>.
 18. Link: CCOPMM, Births in Victoria (reports 1983–1992, 1992–1996, 1996–1998, 1999–2000, 2001–2002, 2003–04), <www.health.vic.gov.au/ccopmm/archive.htm>.
 19. Link: H. Robertson, J. Lumley & S. Berg 1995, 'How midwives identify women as Aboriginal or Torres Strait Islander', *Australian College of Midwives Incorporated Journal*, vol. 8, no. 3, pp. 26–9, <www.ncbi.nlm.nih.gov/pubmed/8604971>.
 20. Link: J. Middleton, M. Halliday & M. Sullivan 2003, *Data Quality Study on Patient Information, Aboriginal & Torres Strait Islander Status* (Mercy Hospital for Women report), <www.healthinonet.ecu.edu.au/key-resources/bibliography?page=62&q=&q_exact=&q_author=&q_keyword=&sorter=year-DESC&health_topic%5B%5D=29&year_start=1840&year_end=2012&lid=3993>.
 21. Link: CCOPMM 2008, Births in Victoria 2005 and 2006, DHS, Melbourne, <[http://docs.health.vic.gov.au/docs/doc/01FB61BD50F38FC6CA257A06001F3E2A/\\$FILE/annrep0506.pdf](http://docs.health.vic.gov.au/docs/doc/01FB61BD50F38FC6CA257A06001F3E2A/$FILE/annrep0506.pdf)>.
 22. Link: CCOPMM 2011, Births in Victoria 2007 and 2008, DoH, Melbourne, <[http://docs.health.vic.gov.au/docs/doc/A1D52F0C89124D42CA25789D00016CE5/\\$FILE/HS1216_births_in_vic_07_08_WEB%20FINAL.pdf](http://docs.health.vic.gov.au/docs/doc/A1D52F0C89124D42CA25789D00016CE5/$FILE/HS1216_births_in_vic_07_08_WEB%20FINAL.pdf)>.
 23. Link: RBDM n.d., 'Aboriginal, Heritage Birth Certificate', <<https://online.justice.vic.gov.au/bdm/certificate-applications?action=getProductDetails&categoryCode=Commemorative&productCode=AHC>>.



24. Links: RBDM Indigenous Access Project, '2009 Aboriginal community information sessions' (regarding birth registrations), <<http://online.justice.vic.gov.au/CA2574F700805DE7/page/About+us-News-2009?OpenDocument&1=70-About+us~&2=60-News~&3=10-2009~>>:
 - a. 'Aboriginal community information session' (poster), <[http://online.justice.vic.gov.au/CA256902000FE154/Lookup/BDMContentSite-PDFs/\\$file/4060_BDM%20Aboriginal%20A3Poster_Final.pdf](http://online.justice.vic.gov.au/CA256902000FE154/Lookup/BDMContentSite-PDFs/$file/4060_BDM%20Aboriginal%20A3Poster_Final.pdf)>
 - b. 'Registering a birth' (information flyer), <[http://online.justice.vic.gov.au/CA256902000FE154/Lookup/BDMContentSite-PDFs/\\$file/4060_BDM%20Aboriginal%20C5Flyer_Final.pdf](http://online.justice.vic.gov.au/CA256902000FE154/Lookup/BDMContentSite-PDFs/$file/4060_BDM%20Aboriginal%20C5Flyer_Final.pdf)>.
25. Link: ABS Information Paper: Cause of Death Certification, Australia 2008: <[http://online.justice.vic.gov.au/CA256902000FE154/Lookup/BDM_MedicalPractitioners_FuneralDirectors/\\$file/InformationPaperCauseOfDeathCertificationAustralia_ABS-1205055001_2008.pdf](http://online.justice.vic.gov.au/CA256902000FE154/Lookup/BDM_MedicalPractitioners_FuneralDirectors/$file/InformationPaperCauseOfDeathCertificationAustralia_ABS-1205055001_2008.pdf)>.
26. Link: ABS 2008, Information Paper: Census Data Enhancement— Indigenous Mortality Quality Study, (2006–07), <[www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/BF364488AEE2FF89CA257501000C3C01/\\$File/47230_2006-07.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/BF364488AEE2FF89CA257501000C3C01/$File/47230_2006-07.pdf)>.



Draft History of the Koori Health Program Development Unit

D R A F T

HISTORY OF THE KOORIE HEALTH PROGRAM DEVELOPMENT UNIT

1976:

DAA PROVIDED FUNDS TO THE VICTORIAN HEALTH DEPARTMENT TO EMPLOY A MEDICAL OFFICER, SIX NURSES, A HEALTH EDUCATION OFFICER, AND 14 ABORIGINAL HEALTH AIDES.

THE 'SPECIAL HEALTH' UNIT WAS ESTABLISHED. ITS ROLE WAS TO PROVIDE A PREVENTATIVE HEALTH/HEALTH EDUCATION PROGRAM, AND TO ASSIST ABORIGINAL PEOPLE TO UTILISE EXISTING HEALTH CARE SERVICES WHICH WERE PROVIDED TO THE GENERAL COMMUNITY.

1980:

REPORT OF DR IAN WRONSKI ON THE HEALTH NEEDS OF ABORIGINAL CHILDREN UNDER THE AGE OF 5, IN THE SHEPPARTON/MOOROPNA REGION.

1980:

ESTABLISHMENT OF THE WORKING PARTY INTO ABORIGINAL HEALTH BY BILL BORTHWICK, MINISTER OF HEALTH, IN RESPONSE TO THE WRONSKI REPORT.

1981:

COMPLETION OF REPORT OF WORKING PARTY INTO ABORIGINAL HEALTH, WITH FOUR MAJOR RECOMMENDATIONS:

- (1) THE TRANSFER OF FUNDS PREVIOUSLY PROVIDED BY THE COMMONWEALTH DEPARTMENT OF ABORIGINAL AFFAIRS TO THE VICTORIAN HEALTH DEPARTMENT FOR ABORIGINAL HEALTH ('SPECIAL HEALTH' UNIT), FOR THE ESTABLISHMENT OF A NETWORK OF ABORIGINAL COMMUNITY-BASED AND ABORIGINAL COMMUNITY-CONTROLLED HEALTH SERVICES THROUGHOUT VICTORIA.
- (2) THE ESTABLISHMENT OF AN ABORIGINAL HEALTH ADVISORY GROUP TO THE VICTORIAN MINISTER FOR HEALTH (VICTORIAN ABORIGINAL HEALTH RESOURCES CONSULTATIVE GROUP).
- (3) THE ESTABLISHMENT OF THE ABORIGINAL HOSPITAL LIAISON OFFICERS SCHEME (STATE FUNDED), WITH 43 POSITIONS RECOMMENDED THROUGHOUT THE STATE.
- (4) THE ESTABLISHMENT OF AN ABORIGINAL LIAISON UNIT WITHIN THE VICTORIAN HEALTH DEPARTMENT (STATE FUNDED).



FIRST MEETING OF VICTORIAN ABORIGINAL HEALTH RESOURCES CONSULTATIVE GROUP.

- 1982: ESTABLISHMENT OF ABORIGINAL LIAISON UNIT UNDER AN ABORIGINAL CO-ORDINATOR.
- 1982: COMMENCEMENT OF ABORIGINAL HOSPITAL LIAISON OFFICERS SCHEME WITH TRANSFER OF 10 ABORIGINAL HEALTH AIDE POSITIONS, AND ESTABLISHMENT OF 6 NEW POSITIONS, (TOTAL OF 16).
- 1982: TRACHOMA AND EYE HEALTH SUB-COMMITTEE ESTABLISHED.
- 1983: ALCOHOL PROGRAMS SUB-COMMITTEE ESTABLISHED.
- 1983: ABORIGINAL DIABETES SUB-COMMITTEE ESTABLISHED.
- 1983: POSITIONS FOR 2 ADDITIONAL ABORIGINAL HOSPITAL LIAISON OFFICERS (MERCY MATERNITY AND ASSISTANT CO-ORDINATOR/LOCUM).
- 1983: REVIEW OF ABORIGINAL KINDERGARTEN ASSISTANCE SCHEME COMMENCED.
- 1984: APPOINTMENT OF ABORIGINAL HEALTH STATISTICS OFFICER.
- 1984: POSITION FOR 1 ADDITIONAL ABORIGINAL HOSPITAL LIAISON OFFICER (ALCOHOL AND DRUG PROBLEMS METROPOLITAN AREA).
- 1985: REPORT OF REVIEW OF ABORIGINAL KINDERGARTEN ASSISTANTS SCHEME, AND TRANSFER OF RESPONSIBILITY FOR THIS SCHEME TO THE DEPARTMENT OF COMMUNITY SERVICES.



- 1985: FIRST DIABETES EDUCATION CAMP AT CAMP JUNGAI.
- 1985: DENTAL HEALTH SUB-COMMITTEE ESTABLISHED.
- 1986: POSITIONS FOR 2 ADDITIONAL ABORIGINAL HOSPITAL LIAISON OFFICERS (BENDIGO AND BALLARAT).
- 1986: COMPLETION OF DRAFT 'Koorie Health Manual'.
- 1986: HACC PROGRAM SUB-COMMITTEE ESTABLISHED.
- 1986: DRUG SUMMIT MONEY AVAILABLE TO APPOINT 6 ABORIGINAL COMMUNITY DEVELOPMENT OFFICERS FOR A 3 YEAR PERIOD.
- 1987: FIRST- INTERNAL REVIEW OF ABORIGINAL LIAISON UNIT NAME CHANGED TO KOORIE HEALTH PROGRAM DEVELOPMENT UNIT.
- 1987: COMMONWEALTH FUNDING NO LONGER AVAILABLE FOR ABORIGINAL HEALTH STATISTICS OFFICER, RESIGNATION OF ABORIGINAL HEALTH STATISTICS OFFICER.
- 1987: MENTAL HEALTH SUB-COMMITTEE ESTABLISHED.
- 1987: WOMEN'S HEALTH SUB-COMMITTEE ESTABLISHED.



Health Commission of Victoria Circular 30/1984, 'Appointment of
Aboriginal Health Statistics Officer'



Health Commission of Victoria
CIRCULAR

555 Collins Street, Melbourne. Telephone: (03) 616 7777

No. 30/1984 Subject APPOINTMENT OF ABORIGINAL HEALTH STATISTICS OFFICER
Date 21 JUNE 1984 Circulation PUBLIC HOSPITALS & COMMUNITY HEALTH CENTRES

The Health Commission of Victoria, in accord with the advice given by the Victorian Aboriginal Health Resources Consultative Group (VAHRCG) to the Minister of Health, is attempting to establish baseline statistics on the health status of Aborigines in Victoria. A question on Aboriginality has been introduced into a variety of existing medical reporting systems.

VAHRCG policy is solely determined by Aboriginal community health representatives. The Consultative Group has clearly demonstrated its wish to have statistics covering many aspects of Aboriginal life and has supported attempts by the Commission to collect information in line with the policies of the Federal Government and Victorian Government.


In April 1984 an Aboriginal Health Statistics Officer, Gavin Jennings, began working from the Commission in conjunction with the VAHRCG. It is his task to promote the collection of information on Aboriginal births, deaths and morbidity from Government departments, health institutions and at the community level. This work, in part, requires legislative and administrative changes. Mr. Jennings will be working to facilitate these changes and will provide advice and support to staff collecting data.

The quality of the data collected to the present time is poor. It appears that information is not being recorded properly and this has led to under-reporting and to the remaining figures being unreliable. The situation requires urgent rectification and it will be a priority task of the officer to ensure that Aboriginality is recorded properly. In addition, the reporting systems of the Registrar of Births, Deaths and Marriages and of the Australian Bureau of Statistics require reappraisal and consultation with these bodies has been initiated.

Until reliable data is obtained, it is impossible to accurately determine the areas of greatest need in Aboriginal health, and also difficult to assess the effectiveness of service delivery to Aborigines. It is hoped that Mr. Jennings will be able to assist medical records administrators, technicians, clerks and health workers contribute to an adequate data base on Aboriginal health.

Mr. Jennings will be in contact with relevant public hospitals, community health centres and Commission staff in the near future to discuss ways in which Aboriginal health recording in Victoria can be improved. I seek your support in liaising with him on ways in which these important goals can be attained. In the meantime any inquiries should be directed to:

Gavin Jennings
Aboriginal Liaison Unit
Health Commission of Victoria
555 Collins Street,
MELBOURNE 3000
Telephone: (03)616 7464


(P.R. Wilkinson)
Secretary

Address all mail to
P.O. Box 4057 G.P.O. Melbourne, Victoria, Australia. 3001



Health Commission of Victoria Circular 6/1984, 'Identification of Aboriginal and Torres Strait Islander patients on hospital records'



Health Commission of Victoria
CIRCULAR

555 Collins Street, Melbourne. Telephone: (03) 616 7777

No 6/1984 Subject IDENTIFICATION OF ABORIGINAL & TORRES STRAIT ISLANDER PATIENTS ON HOSPITAL RECORDS
Date 23 February, 1984 Circulation PUBLIC HOSPITALS

The Aboriginal Health Resources Consultative Group has been established to advise the Minister of Health in Victoria on matters relating to Aboriginal Health.

The Group has wide representation from Aboriginal community organisations throughout the State, together with representatives from the Health Commission, the Department of Aboriginal Affairs, and the Commonwealth Department of Health.

The Aboriginal Health Resources Consultative Group strongly supports the need for the collection of base-line data relating to the health of the Aboriginal community in order that a proper determination of Aboriginal health status can be made, and to assist in the evaluation of current programs being funded.

At the present time, there is a specific code covering persons who identify as being Aboriginal or Torres Strait Islander, in the section headed "Country of Birth" on Patient Registration Forms. However, this code has not always been filled in, and there is a need to amend the method by which Aboriginal or Torres Strait Islander persons are currently recorded.

As Patient Registration Forms at all hospitals will need to be amended with the introduction of Medicare, I write to request your hospital to assist in the collection of Aboriginal health data by including a separate question on the Patient Registration Form, so that the section on the form would appear:

Aboriginal/Torres Strait Islander Yes No Country of Birth

0	0	0		
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(if "Yes" code 08 Country of Birth)

The definition for Aboriginal/Torres Strait Islander is as follows:

"An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander Descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he/she lives."

Please include this definition in your procedure manuals.

The Health Commission's Aboriginal Liaison Unit will ensure that Aboriginal Hospital Liaison Officers and the Aboriginal Community organisations are informed of the changes.

Any queries should be directed to:

Dr Sarah Jo Gome
Aboriginal Liaison Unit

OR

Medical Record Advisors
Information Management Advisory
Section
Planning Division

P WILKINSON
SECRETARY, HEALTH COMMISSION OF VICTORIA
Address all mail to

P.O. Box 4057 G.P.O. Melbourne, Victoria, Australia. 3001



Appendix B:

Invitation, Plain Language Statement, Consent Form and Key Informant Questionnaire



Date

Dear

Re: 'Identification of Aboriginal and Torres Strait Islander peoples in health datasets in Victoria: putting the data into context'

We would be delighted if you would agree to participate in a study to document the policies and initiatives that have been introduced to improve the identification of Aboriginal and Torres Strait Islander people in health datasets in Victoria since 1980.

You have been identified as a key informant in recognition of your experience and expertise in Aboriginal health, specifically Aboriginal health data, policy and/or health service provision.

As such we would be very grateful if you would agree to meet with us to consider the attached schedule of initiatives summarised from the literature and complete the attached questionnaire.

This review forms an important part of the *Victorian Aboriginal Child Mortality Study* currently underway at the University of Melbourne. Information you provide will help place changing levels of identification in the data into context to determine whether annual fluctuations in the number of Aboriginal births and deaths in Victoria have been attributable to actual changes or differential rates of identification. In addition, the information you provide will contribute to the knowledge base of what works to improve Indigenous identification in these datasets.

Please note the enclosed Plain Language Statement and Consent Form.

If you would like further information, please feel free to contact investigators: Ms Bree Heffernan on 03 8344 9336 or breeh@unimelb.edu.au or A/Prof Jane Freemantle on 03 8344 9164 or via email j.freemantle@unimelb.edu.au

This letter will be followed by a telephone call to potentially discuss a convenient time to meet.

Thank you in anticipation for your time.

Kind Regards,

Associate Professor Jane Freemantle
Principal Research Fellow
Centre for Health and Society, Melbourne School of Population Health
The University of Melbourne
Level 4, 207 Bouverie St
Victoria, 3010
Phone: +61 3 8344 9164
Project website: www.vacms.net.au



Plain Language Statement

Identification of Aboriginal and Torres Strait Islander peoples in health datasets in Victoria: putting the data into context

You are invited to participate in a study to document the policies and initiatives that have been introduced to improve the identification of Aboriginal and/or Torres Strait Islander people in health datasets in Victoria since 1980.

This study is being conducted by A/Prof Jane Freemantle (Principal Investigator) and Ms Bree Heffernan (Research Fellow) from the Onemda VicHealth Koori Health Unit, Melbourne School of Population Health, the University of Melbourne. This research will be conducted as a component of the *Victorian Aboriginal Child Mortality Study 1988–2008*.

In addition to providing a valuable snapshot of efforts to improve identification over time, this study will help determine whether annual fluctuations in the number of Aboriginal births and deaths in Victoria have been attributable to actual changes or differential rates of identification.

Should you agree to participate, you will be asked to meet with Investigators to complete the enclosed questionnaire. A summary document has been included for you to consider and build on. We estimate the time commitment required of you will not exceed 30–60 minutes.

We will protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. A copy of your responses to this questionnaire will be included as an attachment in the final report. However your name, role and/or organisation will not be printed with your responses. We would like to acknowledge your involvement in the study by including your name in the Acknowledgements section of the report. However, you will be given the opportunity to accept or decline this acknowledgement.

The results of this study will be made public in a published report that will be circulated widely to the Aboriginal and Torres Strait Islander community, government agencies and academia. A copy of the final report will also be provided to key informants.

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or withdraw any unprocessed data you have supplied, you are free to do so without prejudice.

If you would like to participate, please feel free to contact investigators: Ms Bree Heffernan on 03 8344 9336 or breeh@unimelb.edu.au or A/Prof Jane Freemantle on 03 8344 9164 or via email j.freemantle@unimelb.edu.au

This letter will be followed by a telephone call to organise a convenient time to meet.

Thank you in anticipation for your time.





Centre For Health And Society, The Melbourne School of Population Health, Faculty of Medicine, Dentistry and Health Sciences

Consent form for persons participating in a research project

PROJECT TITLE: *Identification of Aboriginal and Torres Strait Islander peoples in health datasets in Victoria since 1980: putting the data into context*

Name of participant:

Name of investigator(s): A/PROF JANE FREEMANTLE AND MS BREE HEFFERNAN

1. I consent to participate in this project, the details of which have been explained to me, and I have been provided with a written plain language statement to keep.
2. I understand that after I sign and return this consent form it will be retained by the researcher.
3. I understand that my participation will involve an interview and I agree that the researcher may use the results as described in the plain language statement.
4. I acknowledge that:
 - a. the possible effects of participating in the interview have been explained to my satisfaction;
 - b. I have been informed that I am free to withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data I have provided;
 - c. the project is for the purpose of research;
 - d. I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements;
 - e. I acknowledge that I can choose to be identified by name in the final report and in any publications arising from the research or to be identified by a pseudonym;
 - f. I have been informed that a copy of the research findings will be forwarded to me, should I agree to this.

I consent to participating in this project

yes no

I wish to receive a copy of the summary project report on research findings

yes no
(please tick)

I consent to my name being published in the Acknowledgement section of the final report and subsequent publications

yes no
(please tick)

Participant signature:

Date:



Key Informant Questionnaire:

Identification of Aboriginal and/or Torres Strait Islander People in Health Datasets in Victoria Since 1980: Putting the Data into Context

Key Informant Questionnaire (to be completed during interview)

1. Which datasets does your knowledge of initiatives and/or policy regarding Indigenous identification apply to? Please tick as many as relevant.
 - Victorian Admitted Episodes Dataset (identification in public/private hospital patient records)
 - Aboriginal Hospital Liaison Officer Collection (AHLO or KHLO)
 - Victorian Perinatal Data Collection (Victorian midwife birth data collection)
 - Victorian Registry of Births (birth registrations)
 - Victorian Registry of Deaths (identification in Death Registrations and on Medical Certificates of Cause of Death forms certified by Medical Practitioners e.g. [GPs or in hospital])
 - Consultative Council on Obstetric and Paediatric Mortality and Morbidity (Child death review)
 - Australian Census of Population and Housing.
 - Not specific to a single dataset listed.
 - Other (please state)_____



2. The following tables 2.1 and 2.2 include potential barriers to achieving accurate identification.

2.1 In your professional experience: please tick a box to indicate which previously identified barriers to identification you believe to be valid in Victoria.

Previously-published barriers to identification	please a one box in each row					Any comments relating to your selection?
	Not valid	Low validity	Med validity	High validity	N/A	
Indigenous question is not asked by staff at registration						
<ul style="list-style-type: none"> Staff member doesn't know why the question should be asked Staff member doesn't want to appear discriminatory Staff member feels the question is irrelevant to treatment of the patient Staff member feels the question isn't relevant (e.g. they don't have any Indigenous patients) Staff member fears a negative response to the question Staff member is too busy to ask all questions at registration Staff member guesses Indigenous identity based on appearance 						
Indigenous person chooses not to declare their status on a form (e.g. birth/death registration form)						
Indigenous patient chooses not to declare their status in response to the question asked						
<ul style="list-style-type: none"> The Indigenous patient wishes to avoid being identified in the hospital 						
A language barrier exists between staff and patient						
Other barriers in your professional experience (please specify and tick):						





2.2 In your personal experience: please tick a box to indicate your personal experience as a user of health services and/or when registering a birth or death. If you would prefer not to answer questions relating to your personal experience, please tick the 'Elect not to answer' box.

	please a one box in each row					Any comments relating to your selection?
	Not valid	Low validity	Med validity	High validity	N/A	
The Indigenous identification question is <u>not</u> asked by staff						
I choose <u>not</u> to declare my Indigenous identification when asked (if applicable)						
I choose not to identify my Indigenous identification on a birth/death registration form (if applicable)						
Other barriers/enablers to identification from personal experience (please specify and tick):						



- 4 What initiatives and/or policy do you believe are important for achieving accurate identification? Please tick a box to indicate what you believe to be the level of importance (select N/A if you have no knowledge of the policy/initiative).

Initiatives and policies	please a one box in each row					Any comments relating to your selection?
	Not valid	Low validity	Med validity	High validity	N/A	
Training: Cultural respect training for all staff						
Training: Data collection training specific for registration staff including why and how to ask the question (hospital registration staff, funeral director and midwife),						
Site-based Aboriginal Liaison Officer roles						
Financial incentives rewarding positive identification of Indigenous patients (e.g. hospital-based WIES)						
Accountability of line managers and senior managers (e.g. personal performance measures relating to identification)						
System enhancements: mandatory fields, removal of default values of 'Not-Aboriginal' from registration systems						
Development of National Best Practice Guidelines re Identification						
Materials encouraging Indigenous people to identify (posters and pamphlets at point of admission)						
Community-based visits to communicate why the information is collected and how it is used						
Strengthened relationships between health service and local community-controlled organisation						
Routine feedback provided by government to health services and community organisations using the data collected						
Site-based Aboriginal-specific health clinics						
Other (please specify and tick):						



Appendix C: Summary of Key Informant Responses to Each Question in the Questionnaire

Question 2.1: In your professional experience: please... indicate which previously identified barriers to identification you believe to be valid in Victoria

The first column of the following table includes the list of previously published barriers to Indigenous identification provided to informants. The second column lists comments relating to informants' selection regarding validity.

Theme	Policy/government/academic informants (direct quotes)
Indigenous question is not asked by staff at registration	<p>Medium validity, but improving.</p> <p>Staff are more likely to ask the Indigenous question at registration if they've attended an education session; their confidence is likely to increase.</p> <p>The consistency with which the Indigenous question is asked is in question.</p> <p>Not in a position to comment on processes at a service level. Most issues of identification have been brought to our attention in the course of discussions with Health Department colleagues.</p> <p>We've been working on a staff training package for the last three years. Cultural background and family connections of the client are the first questions on the intake form. Therefore, all front desk staff are trained to ask the question.</p> <p>In this hospital, data is backed up from the previous visit, even if the patient declared differently.</p> <p>Very important to ask the question.</p> <p>We're not 100% but we're pretty good at asking the question.</p> <p>In this hospital, the Indigenous question is asked by registration staff but there is room for improvement. Identification workshops are carried out to communicate the significance of identification.</p> <p>Staff have admitted to me that they do not ask the question.</p> <p>If staff don't ask the question, support can't be provided to the patient.</p> <p>I'm assuming staff ask the question but I still pick up complications down the track when I speak to patients and they report that they weren't asked.</p> <p>Every person must be asked the question and must not be judged on appearance.</p> <p>This is the biggest barrier. If an AHLO is part time and a patient isn't identified, they slip through the cracks and miss out on services such as appropriate discharge planning.</p> <p>Not applicable—the individual isn't asked the question at birth or death. Parents or next of kin are asked at registration or by the funeral director. Identification on the medical certificate of cause of death is provided by the certifying doctor (often from the hospital record) or Coroner. The latter derives the information from the police report. This may have been a barrier for funeral directors in the past but not any longer. BDM will investigate if identification is discrepant between these sources.</p>

Staff member doesn't know why the question should be asked	<p>Uncertainty whose responsibility it is to ask the question (e.g. General Practitioner or receptionist)</p> <p>Mainstream funeral directors are unlikely to know why the question should be asked. Feedback from funeral directors has supported this assumption.</p> <p>Staff members in this hospital know why question must be asked.</p> <p>It's important to work close with staff members to build cultural competency.</p> <p>Most staff at this hospital have attended training so they should know why.</p> <p>In identification workshops we highlight the importance of asking the question to the WIES loading.</p> <p>This should be low as most staff should know why by now.</p> <p>In a mainstream setting I can only focus on the details of the program and how identification is important for quality of care. Staff need a deeper cultural understanding of the importance of data to closing the gap and cultural safety in a mainstream setting.</p> <p>This hospital has ongoing informal training for all staff members, yet there's still room for improvement.</p> <p>Staff are still not educated to know why they are asking the question. Services should have roles/staff to engage with the community to reduce the fear of a negative response and reinforce that the health service does have Aboriginal patients.</p> <p>This may have been a barrier in the past e.g. of medium importance 10 years ago, and of high importance 20 years ago.</p>
Staff member doesn't want to appear discriminatory	<p>Staff members can actually experience a backlash from patients.</p> <p>Some people believed it was racist to ask.</p> <p>Very high.</p> <p>Front line staff can be concerned about appearing discriminatory and offensive, particularly if they are unsure why the question needs to be asked, they can't make the connection with care provided later.</p> <p>'we are all the same'</p> <p>I have heard this from staff quite often.</p> <p>This has been mentioned by staff, especially when the question is asked in a queue raising privacy issues.</p> <p>People don't know the question is mandatory and has been since 1993, all staff should know it (e.g. Nurses, Social Work etc).</p> <p>This could be one factor that contributes to a person's discomfort in asking the question.</p>
Staff member feels the question is irrelevant to treatment of the patient	<p>Perhaps until the reasoning is explained. Staff may wonder why they ask this question and not questions about other ethnicities.</p> <p>This is why we have ongoing competency training.</p> <p>Staff members may not be aware of the importance of asking the question.</p> <p>Most staff don't understand the link between identification and the provision of services and treatment. A lot of staff are shift workers so it's not their fault that they are unaware of the link.</p> <p>Funeral directors know the question is relevant.</p>



Staff member feels the question isn't relevant (e.g. they don't have any Indigenous patients)

There is a belief that Aboriginal and Torres Strait Islander patients don't attend private hospitals.

This is likely to be the biggest barrier in Victoria (e.g. Some General Practitioners believe there are no Aboriginal people in Victoria).

Varies for staff depending on location of the hospital and if they believe they have a local Aboriginal community.

Many people didn't and still don't believe there are Indigenous people in Victoria.

Answers would likely vary from hospital to hospital depending on the size of the hospital.

There may be some confusion with funeral directors that the Aboriginal Funeral Service coordinates all Aboriginal funerals, when in fact it doesn't. This may be a barrier to asking the question.

Different staff members may feel differently regarding relevancy of asking the question (e.g. This barrier may be of high validity if referring to clerical staff)

Staff sometimes make assumptions regarding Aboriginality.

Most staff at this hospital know we have a lot of Indigenous patients, whereas agency staff may be less aware.

Some staff think this hospital hasn't got any Indigenous patients, however, this is corrected during identification workshops. Older staff are likely to be more aware than recent employees.

Staff known Indigenous patients come through this hospital.

Staff know they have Indigenous patients, but the question is still not being asked.

Staff member fears a negative response to the question

Fear of response from non-Aboriginal person.

This is likely to be a significant barrier in Vic.

Some staff members were afraid of a violent response.

The question is part of the intake process and staff are now aware that it needs to be asked. Fear of a negative response may have been a barrier in the past, not now.

Health and safety issue—some may not ask in the Emergency Dept to avoid putting themselves at risk.

Staff don't want to offend. They may be more fearful when asking a seemingly non-Aboriginal person.

Staff fearing a negative response may have been a barrier prior to Identification workshops.

Very high—I have heard this often from staff not wanting to 'cop the flack' from patients.

Staff members (including midwives) are likely to fear a negative response.

Staff training should result in staff consistently asking the question and responding when patients ask why the question is asked.

This is an issue, the fear of a negative response both from Indigenous and non-Indigenous patients.

From both non-Aboriginal and Aboriginal patients.

Question is not asked, therefore they aren't fearing a negative response.

Staff member is too busy to ask all questions at registration

Being too busy to ask is not an excuse. Most staff ensure other questions are asked at registration so clearly there are other barriers that come into play when it comes to asking 'the question'.

This is only relevant in the Emergency Dept.

Should not be the case.

Staff are busy but not too busy. If they are unsure why the question must be asked, they are likely to skip it.

This may be an issue in the Emergency Department.

Not sure first hand if this is a barrier but it's possible. If staff ask the identity question they also need to ask the next question about linking with services like the AHLO.

Staff may be busy but question must be asked.

If all other boxes are ticked except the Aboriginal status question, then staff are not too busy to ask.

BDM generally doesn't meet the person.



Staff member guesses Indigenous identity based on appearance	<p>Some staff members ask the question based on appearance.</p> <p>Although, some clerical staff are aware of the WIES funding implications.</p> <p>Not sure how often staff guess Indigenous identity based on appearance.</p> <p>Occasionally.</p> <p>Perhaps prior to Indigenous workshops.</p> <p>This happens—we have seen Indian and Sri Lankan patients identified as Aboriginal.</p> <p>Staff may have the perception that Indigenous people are supposed to look a certain way.</p> <p>Some staff still have the perception that they can tell based on appearance.</p> <p>It happens.</p> <p>Certainly.</p> <p>There are examples of Aboriginal-identified birth and death registrations where the surname raises suspicion that the individual may be of a foreign origin. These are checked by BDM staff.</p>
Indigenous person chooses not to declare their status on a form (e.g. birth/death registration form)	<p>Depends on previous experience with the service provider (negative/positive)</p> <p>Some patients will leave the question blank when completing a pre-admission form because they're not sure what it means for them and they aren't being walked through the form by staff.</p> <p>Willingness to identify depends on situation and setting.</p> <p>A persons' declaration of their Indigenous status on a form is dependent on a combination of stigma and perceived benefit.</p> <p>Indigenous people are proud to say they are Aboriginal in this health service because the community is solid here.</p> <p>A non-Aboriginal mother may elect not to identify the father as Aboriginal when asked, but might feel comfortable reporting his Aboriginality on a form.</p> <p>Identification changes depending on whether a person is willing to declare their status at the time or not; influenced by whether the patient feels culturally safe/unsafe.</p> <p>Answers may change at different stages of life, for a whole range of different reasons.</p> <p>Indigenous person may feel it's less confronting to be asked the question on a form as opposed to being asked by a staff member.</p> <p>Often Indigenous patients don't want to be targeted or treated differently.</p> <p>Patient may feel overwhelmed filling out a form or may have difficulty reading it—forms are rarely fully completed.</p> <p>Depends on the patient's personal experiences and knowledge of their identity. Literacy may also be a barrier.</p> <p>I haven't seen an Indigenous patient not identify but it would depend on someone's background and experiences. Some factors might include if they were removed as a child or adopted, or if they wish to connect with the community (referrals to 'link up' happen often at this hospital to support people establish their identity).</p> <p>I think this happens but I have no proof because a patient may feel too embarrassed to admit to me, the AHLO that they chose not to identify.</p> <p>Some patients may not have the skills to read the questions on a form.</p> <p>Some choose not to identify particularly if they don't want to see the AHLO. Accurate data, sometimes non-Indigenous identifying takes place.</p> <p>They have the right not to declare their status.</p> <p>An Indigenous person choosing to declare their status is independent of the question being asked on a form or face-to-face. It should not be hard to ask face-to-face—staff must ensure the data item is accurately recorded electronically.</p> <p>A lot of Indigenous patients struggle with reading and writing. In addition, there's a fear of how or are they are going to be treated.</p>



<p>Indigenous patient chooses not to declare their status in response to the question asked</p>	<p>Patients have the choice to identify yes or no and if they feel safe, they might say yes, depending on how the question is asked.</p> <p>Willingness to identify depends on situation and setting.</p> <p>Identification changes depending on whether a person is willing to declare their status at the time or not; influenced by whether the patient feels culturally safe/unsafe.</p> <p>Depends on the environment. An Indigenous patient may choose not to declare their status because they don't want to appear on a database, because they don't want the AHLO to know or don't want to be singled out, or don't understand the importance of identifying.</p> <p>Answers may change at different stages of life, for a whole range of different reasons.</p> <p>There is a quicker and more accurate response if the question is asked face to face.</p> <p>Identification rates are likely to be higher if asked face-to-face rather than on a form. Although this depends on how the question is asked and the situation.</p> <p>Non-Aboriginal patients may choose to identify as Aboriginal because they believe they could receive extra benefits.</p> <p>Hard to comment, I wouldn't know.</p> <p>Some Aboriginal patients don't care—we must tell them why it's important.</p> <p>The question is verbally asked in this hospital and worded in a way that reflects the services offered here, including services for partners. Indigenous patients are more likely to identify if the question is asked verbally rather than on a form.</p> <p>Response if question is asked may be 'Why do you want to know?' There is still a fear of welfare stigma, that someone will come and look at their home or take their baby away.</p> <p>Not high anymore. Indigenous people trust babies are not being taken away from them.</p>
<p>The Indigenous patient wishes to avoid being identified in the hospital</p>	<p>Potentially dependent on the cause of admission.</p> <p>Depends on the patient's relationship with the AHLO.</p> <p>An Indigenous patient might not identify themselves or their child in hospital for a variety of reasons.</p> <p>The Indigenous patient may avoid being identified in the hospital due to feeling uncomfortable/unsafe or to not wishing to see AHLO.</p> <p>Indigenous patient may wish to avoid identifying due to a fear of being treated differently in the hospital.</p> <p>Perhaps to avoid the AHLO and/or avoid discrimination if perceived not to appear Aboriginal.</p> <p>Indigenous patients are usually happy to identify.</p> <p>We will never know if there are people that want to avoid being identified.</p> <p>If the patient doesn't want the AHLO to know they're there that's fair enough, we must respect their choice.</p> <p>Need for more than one AHLO funded position so that the patient has choice in who they see. A male patient may choose not to identify if they know the AHLO is female.</p> <p>Sometimes it can happen, especially if the question is asked while the patient is in a queue around other patients.</p> <p>PAS: Pregnancy Advisory Service—The woman has already been identified as Aboriginal, however she has the choice of using the service or not.</p> <p>The question should be asked at every episode as people may change their response depending on reason for that admission.</p> <p>Not applicable.</p>



<p>A language barrier exists between staff and patient</p>	<p>Language unlikely to be a barrier in Victoria.</p> <p>Language barrier is unlikely in Victoria, unless due to remote area transfer (e.g. Children's Hospital).</p> <p>Language could act as a barrier if the patient doesn't understand what is being asked (e.g. they don't understand what the Registrar is asking, potentially because they have a foreign accent).</p> <p>Language is unlikely to be a barrier unless patient is from interstate.</p> <p>Language may be a barrier between patients and international health graduates working in this health service, but it is unlikely to impact on identification. Therefore, orientation sessions are carried out to try and eliminate any language barrier e.g. what does it mean when a patient responds with the word 'deadly'?</p> <p>This is less likely to be a barrier in Victoria though we do service patients from across Australia.</p> <p>Language is unlikely to be a barrier in Victoria, unless due to interstate transfer (e.g. Children's Hospital).</p> <p>This is less relevant. If a person is coming from a remote community, it is known that they are Indigenous anyway.</p> <p>Language unlikely to be a barrier.</p> <p>Language may be a barrier depending on the client's level of education.</p> <p>Not so relevant in Vic.</p> <p>A language barrier between staff and the patient is likely to be higher in remote communities than in metropolitan areas.</p> <p>False positives may occur when foreign patients don't understand.</p> <p>False positives occur from overseas people who don't understand that the question is asking for 'Aboriginal and Torres Strait Islander' status rather than Indigenous status in general.</p> <p>Not in the sense of not speaking English as a first language but definitely in a communication sense. Language is more than just words. The hospital environment can be intimidating and the way staff communicate with patients can 'be scary'. A patient may make a decision whether to identify based on the way they were asked or how scary the staff member registering them was.</p> <p>A lot of our people are shy and won't say anything when asked questions.</p> <p>Unless English is a second language.</p> <p>Not really, most patients are from Vic.</p> <p>Unlikely to be a barrier unless the patient is from interstate. Staff are directed to be patient and take their time assisting the patient.</p> <p>Very low.</p>
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Question 2.2: In your personal experience: please... indicate your personal experience as a user of health services and/or when registering a birth or death

The first column includes the three questions asked of informants about their personal experiences. The second column lists comments relating to their responses. Other barriers suggested by informants are listed at the end of the table.

Theme	Policy/government/academic informants (direct quotes)
The Indigenous identification question is not asked by staff	<p>More likely to find the question on a form than asked face-to-face.</p> <p>Less likely to be asked by clerical staff than midwives</p> <p>I have not been asked the question verbally, only on a form.</p> <p>I'm never asked by General Practitioners, but I often answer the question by ticking a box on a form. I feel it's easier to respond on a form than to a question.</p> <p>Staff have asked previously but not always.</p> <p>Staff just assume.</p> <p>The use of Aboriginal services on a regular basis strengthens community relationships with Koori services' staff members and the question is therefore not needed to be asked at all times.</p> <p>I know of friends who haven't been asked.</p> <p>I have never been asked in an ambulance or hospital. Although I was asked once by 'Nurse on Call'.</p> <p>The Indigenous identification question has been previously asked of me on a form.</p> <p>I have never been asked in a medical setting.</p> <p>I've never been asked – certainly not in a mainstream service.</p> <p>Haven't been asked verbally, however it has always been on a form.</p> <p>I have not been asked to identify by a General Practitioner.</p> <p>When I haven't been asked, I ask staff why they didn't ask the question.</p> <p>Should the question be asked repeatedly if the patient is already registered as Indigenous in the system?</p>
<p>I choose not to declare my Indigenous identification:</p> <ul style="list-style-type: none"> when asked (if applicable) on a birth/death registration form 	<p>I am very proud—I am happy to identify.</p> <p>I am proud of who I am and my cultural beliefs so I would definitely identify.</p> <p>I always declare, I am proud of who I am. In the past Indigenous people may have hidden their Indigenous status in order to protect their families, due to past unsafe practices.</p>
Other barriers/enablers to identification from personal experience	<p>Not being asked the question was a barrier to answering no in my case and my children's.</p> <p>There were no posters at admission. Unless you were feeling very strong minded about identifying, the opportunity to say yes or no wasn't there.</p> <p>Doctors and Nurses judging and making assumptions.</p> <p>Lack of understanding in the hospital as to the importance of asking question.</p> <p>Not being asked/identified at the first hos[p]italisation, the[n] being asked [a]t a later stage.</p> <p>Some Aboriginal people had reported that they chose not to identify due to the belief that they would be made to wait longer and given different treatment.</p> <p>Being worried about how the staff would judge me and question my Aboriginality based on my appearance. For example, question 'how much' Aboriginal I am.</p> <p>Enabler: if the client presents with family members or has visitors in hospital from the Indigenous community... Aboriginality may become more obvious to staff or at least prompt them to ask about Indigenous status.</p>



Question 3: Please examine the summary of initiatives and policy... Are there any initiatives or policies you can recall that are missing?

The following table lists informants' responses by theme arising from thematic analysis. Four themes were identified by investigators.

Theme 1: Education and support materials
Training of registration staff provided by and in this hospital.
Educating international medical/nursing graduates [in the hospital], helping them understand Aboriginal culture and language/phrases.
Staff orientation: the AHLO delivers a half hour PowerPoint presentation on the ICAP Program and Liaison services. This presentation doesn't go into detail about the bigger picture regarding health, wellbeing and identification.
Half hour education programs initiated and conducted by the hospital for 30 minutes, four times a year. All staff expected to attend from Environmental Services throughout.
Separate cross-cultural training workshops.
Hospital-run identification workshops are an opportunity for staff to share their past experiences and hear other peoples' perspectives. We instruct staff to never assume a patient's identity. Staff are given the opportunity to ask the AHLO questions after the session.
'Working with Aboriginal patients' training for hospital staff.
<ul style="list-style-type: none"> • This consists of a 15min introductory talk with a 45min optional extended program. The session is delivered by me, the AHLO, on request, but twice a year management send out a letter requesting departments undertake the training and this is offered to all departments. • In this talk, I discuss what my life has been like as an Aboriginal woman and what my mother and my grandmother's experiences have been so that staff can understand why patients are the way they are, and be aware the issues are current and not in the past as most think. I talk about identity and why I see myself as Aboriginal rather than non-Aboriginal. I explain how demeaning it is to have your culture questioned ('you're only a little bit Aboriginal') and how culture is rarely questioned of people of other cultures.
Feedback from staff has been very positive and the number of identified patients tripled after we monitored sessions at a site. There was a bigger response from Nurses than Clerks. Some Nurses commented that they didn't understand, and following the training they did. Nurses were able to identify Aboriginal patients on the ward after they had been incorrectly identified at admission. Twelve Nurses went on to work in remote communities.
AHLOs provide regular training to capture all staff of the hospital due to quick changeover of staff.
The AHLO's role is highlighted in orientation sessions to all staff.
Staff from each department of the hospital goes through cultural training to encourage staff to make Aboriginal health their business as well.
2008: Cultural awareness seminars provided throughout the hospital and Medical School by Wathaurong Aboriginal Cooperative.
Aboriginal Associates Program was introduced to provide specific cultural training to staff in all areas of the hospital. These staff members receive a badge to encourage other staff members to ask questions of them if in doubt (AHLOs can't cover the whole hospital at all times).
Partnership with the co op midwife where she will undertake our training so she can be the 'midwife' for low risk pregnancy instead of at the hospital.
Patient care books include information on the AHLO/services, and an insert is included for the trainee doctors.
Quality of care sessions/materials: Articles are prepared throughout the year to raise awareness of Indigenous health outcomes and the importance of providing quality care.
Cue cards for registration staff consisting of suggested responses to potential negative responses to the question being asked.



Theme 2: Partnerships

The local partnership agreement between the health service and Aboriginal Community Controlled Health Organisation is underpinned by an annual action plan annual priorities. There is a taskforce comprising of the ACCHO board and senior health service staff.

Partnership with the coop whereby the midwife at the co-op can provide antenatal care and accompany the woman to appointments at the hospital. This has resulted in greater identification of expecting mothers as hospital staff are now familiar with the Aboriginal midwife and they can attend at the coop as well as having support if they do need to go to the hospital for any reason to help them.

1997: Child Protection Services (CPS) initiated the 'I'm an Aboriginal Dad' program (with the Mercy Hospital) to support Aboriginal fathers by helping them to engage with the community and approach Koori services on offer.

Theme 3: Validation and quality assurance

Currently, the health service is developing a 'RiskMan' incident follow-through process to pinpoint the staff member responsible for an Aboriginal patient being incorrectly identified as non-Aboriginal because they did not ask the question.

A mapping exercise was carried out a few years ago by the Health Information Manager at this hospital to target those staff members not asking the Indigenous question (when data is entered on the system, the staff member's name initials are recorded).

Internal audits are important to ensure issues around Indigenous Identification are isolated and identified. Data has been used in this hospital to discover which staff members are not performing according to process guidelines.

In the early 1980s Health Information Managers provided daily [inpatient] printouts for the AHLO to inform them how many Aboriginal inpatients there were in the hospital.

2003: a study carried out at the Mercy which highlighted the importance of capturing Aboriginal's father's identity.

2009–2010: Local benchmarking against Closing the Gap indicators.

In late 2010 the issue of identification was raised again and various hospital areas were asked to provide a monthly report on how many women had been identified as Aboriginal, with the aim of understanding what was happening prior to introducing new identification initiatives.

Theme 4: Cultural acknowledgment and safety

Flags at the hospital make a big difference to Koori patients and those driving past.

Aboriginal artwork throughout the hospital.

ICAP banner and Indigenous flag is in the entrance. Aboriginal and Torres Strait Islander desk flags have been placed at admission to A&E [Accident and Emergency] and acute.

An acknowledgment plaque introduced to the hospital.

Posters for all nations in palliative care.

This Health Service developed a Reconciliation Action Plan approximately 10 years ago in recognition of the Stolen Generations.

Identity posters with photos of community members posted in ACCHOs and doctors surgeries that are frequented by the community.

The AHLO visiting the maternity ward and supporting the non-Koori mothers (with Koori fathers).

Koori Mail and *Deadly Vibes* put in all waiting rooms, including dialysis to create a cultural safe place.

Indigenous menu introduction: the chef can cook fish/kangaroo for patients upon request.

A Healing Place has been established in the hospital.

The hospital prints a 'Quality of care' report in the district newspaper, which includes a section on the ICAP program at the hospital. It is hoped that this will change how people in community think about the hospital.

Services are provided for patients without a health care card (the past CEO wanted an open door policy for Aboriginal people).

We have developed a fridge magnet in the Aboriginal colours with the [AHLO's] mobile and office telephone number. This has been I think the biggest success as most Aboriginal homes I have been to have one!



Question 4: What initiatives and/or policy do you believe are important for achieving accurate identification?

The first column lists initiatives and policies provided by investigators to informants in the questionnaire. The second column lists informants' comments supporting their selection of level of importance. Other initiatives suggested by informants are listed at the end of the table.

Initiatives and policies	Comments accompanying informants' responses regarding level of importance
<p>Training: Cultural respect training for all staff</p>	<p>Cultural respect training may create a consciousness, however most likely to have a low impact on identification.</p>
	<p>Training is good for students when they first arrive. It is more difficult the longer a person is in the hospital. Cultural respect tutorials at this hospital provide students with a midwifery model as opposed to a medical model.</p>
	<p>Cultural respect training likely to promote accurate identification if given only to staff treating patient as opposed to registration staff.</p>
	<p>Cultural respect training provides an environment and atmosphere that values Aboriginal culture.</p>
	<p>Very important, however, there are limited policies regarding training for staff. A sustained program of staff training is required.</p>
	<p>Staff members are unlikely to attend cultural respect training; however, it's important for the organisation to promote cultural safety.</p>
	<p>Should focus on cultural competency and it must be quality training through hospitals.</p>
	<p>Staff members should be encouraged to come face-to-face with an Aboriginal person. Training should not be one-off, staff need to remember what they've learnt.</p>
	<p>Not in a position to comment on most of these at a service level and answers would vary from hospital to hospital.</p>
	<p>Cultural respect training is important in maternity services where midwives and doctors have an opportunity to form a relationship with the patient.</p>
	<p>Very Important.</p>
	<p>Very important.</p> <p>There is a place for cultural respect training, however, it can often create a divide between Aboriginal and non-Aboriginal patients and make participants feel intimidated and judged. Training that incorporates why Aboriginal patients may feel and act a certain way can be more effective than historical perspectives. Most people who work in the health system are caring people—they are interested in how to best care for people so emphasising how identification can help patients get the supports they need can be effective.</p>
	<p>Cultural respect training for all staff is important for achieving accurate identification. Tutorials are performed throughout this hospital.</p>
	<p>Cultural respect training is compulsory at this hospital.</p> <p>All staff should be trained and aware through orientation regardless of their position, everyone from the top to cleaner. Everyone remembers the people who spoke during orientation.</p>
	<p>This is important not only for funeral directors but for all BDM staff. Customer service staff need to be culturally aware to build customer confidence and break any perceptions.</p>



Training: Data collection training specific for registration staff including why and how to ask the question (hospital registration staff, funeral director and midwife)

Data collection training is likely to be important for understanding why the question needs to be asked.

Data collection training specific for registration staff likely to be effective only for hospitals with a significant number of Indigenous patients.

Training is a valuable tool for staff that may not feel comfortable asking the question.

Very important, however, there are limited policies regarding training for staff. A sustained program of staff training is required.

Including some cultural respect elements in data collection training.

Data collection training specific for registration staff has to happen to highlight the significance of asking the question. Staff are busy but they need to know how important it is to ask.

Data collection training should be part of a broader data quality training package, incorporating Indigenous data but not advertising it as an Aboriginal program.

Data collection staff need the support to:

- understand why the question must be asked and how they are a vital part of the process
- how to cope with asking the question of a grieving family
- feel confident to ask the question in the context of their work and their knowledge and understanding
- ongoing support so if have a bad experience they can talk over it and can learn in a non-threatening environment.

Data collection training should be part of Cultural respect training.

This training is good for all staff. However, It's not 100% the AHLO's role to train staff and having an outsider deliver training reinforces the importance of identifying.

Data collection training specific for registration staff is vital, particularly in a hospital setting.

Data collection training is more important than cultural respect training for improving identification. Should be a short 20-min session.

Very important.

Staff members that have been employed by this hospital for a long time find it easier to ask the question and refer a patient to the AHLO.

Including the value of the question to health and wellbeing not just the link with WIES and hospital accreditation.

Both cultural respect and data collection training are equally important, since it is vital for staff members to know why the question is asked (to collect good information and provide services to Aboriginal women and appropriate referral pathways).

This is important not only for funeral directors but for all BDM staff. Customer service staff need to be culturally aware to build customer confidence and break any perceptions.



Site-based Aboriginal Liaison Officer roles

AHLOs have important roles to play in hospitals; including overseeing that identification is happening.

Site-based Aboriginal Liaison Officer roles the most time and cost effective way to improve health/identification.

AHLO midwife presence is likely to result in good outcomes.

AHLOs are important as they have cultural understanding of what behavior is expected.

Site-based Aboriginal Liaison Officer roles are important to break down barriers for achieving accurate identification. It has been identified that the presence of AHLOs in a health service often improves identification of Aboriginal patients.

It is intuitive that the support provided by Liaison Officers enables patients to recognise why they are being identified. Liaison officers are more important than financial incentives.

AHLOs are important in identifying Indigenous individuals; however they also rely on others to collect the information. Importantly, not every Indigenous mother wishes to interact with AHLOs, therefore other methods are needed to identify patients in a hospital setting.

AHLOs are important in some hospitals, where there is a need (e.g. Public hospitals rather than Private hospitals).

AHLOs are not employed by all hospitals and are allocated depending on the population of the community. AHLOs improve awareness of the importance of identifying Indigenous people.

AHLOs are crucial.

Very important. Patients need contact with someone they can relate to. And having met them feel comfortable in contacting them and interacting, a Aboriginal staff member if not known can be a little intimidating to some staff.

The AHLO is in isolation and identification is too big for one person to tackle on their own.

AHLOs roles are highly important and highly demanding. They act as the community links to services by breaking down barriers and facilitating Aboriginal women's access.

Extremely important. There were 12 AHLOs in the beginning, I'm very proud of how the numbers have grown.

BDM is in the process of recruiting a Koori Customer Service Officer.



Financial incentives rewarding positive identification of Indigenous patients (e.g. hospital-based WIES)

WIES not as effective at improving identification as thought it would be.

The financial incentive is outrageous.

The WIES loading is capped and WIES dollars are not being translated into an AHLO budget.

Financial incentives are likely to raise awareness, however, the reality of WIES is that it doesn't actually equate to increased dollars. Greater identification may just mean that the health service reaches its WIES cap quicker and the Aboriginal Health Program continues to compete internally for dollars. There is a risk in assuming a WIES loading that identification will result in a greater availability of funds to reinvest in Aboriginal programs, which is not necessarily the case. The WIES loading is really only beneficial to large health services with high volumes of Aboriginal attendances.

If all managers knew the WIES supplement is attached to baby admissions, there'd likely be an increased focus and discussions with clerical staff.

The WIES loading is not being used properly by health services.

WIES incentives should be promoted as data quality improvement rather than Aboriginal funding. Evaluating how much each admission costs provides a clearer picture of how much needs to be invested in Aboriginal health.

The WIES loading might have had a bigger impact for smaller hospitals. Numbers of identifications jumped when the 10% WIES loading was first introduced; however, there was little difference when the loading increased from 10% to 30%.

Financial incentives are important as this hospital is expected to invest time to WIES.

WIES loading is vital for funding of Aboriginal activities in a hospital.

WIES funding encourages the hospital to get things done. However, where does the funding go when identification is accurate?

Not the answer for improved identification.

It is important for AHLOs to have access to funds to further review the issue of identification.

WIES funding may have a positive impact in larger hospitals, since they gather larger sums of money than smaller hospitals. WIES funding should be allocated back to the Aboriginal community by employing more AHLOs and funding more Aboriginal services and activities.

WIES funding is important, with high rural transfers and costly neonates, identification can result in many WIES dollars. But we don't want the WIES loading to be the main driver for identification.

WIES loading is a topic covered in the Identification workshops, but this shouldn't be the main message.

The WIES copayment is a good bargaining tool with hospital management. I have also used it as a tool for convincing staff that identification benefits the health service.

WIES funding is a positive initiative, but it must be invested into Aboriginal programs.

WIES is important but also a hindrance. How is the bucket of WIES money being spent?

Don't get WIES funding – not an [inpatient] hospital.

It is vital to obtain funds through WIES loading, but it must be ensured that funding is invested in Aboriginal Health and provides some assistance to Aboriginal women (e.g. Taxi vouchers, meal vouchers).

WIES is important and should be rolled over into investment for programs.



<p>Accountability of line managers and senior managers (e.g. personal performance measures relating to identification)</p>	<p>All staff members are accountable for identification because it is so important for the patient's care.</p> <p>Don't know this would be measured.</p> <p>Accountability of line managers is important to identification and to how the question is being asked by staff members. The accuracy of data collected is difficult to measure.</p> <p>The Action plan in hospitals and ACCHO partnership agreement is likely to have some impact.</p> <p>Line managers are accountable for ensuring the question is asked but can't be made accountable for the actual data/numbers.</p> <p>Aboriginal health is everyone's responsibility and should be included in every staff member's performance plan, otherwise it won't get onto the agenda.</p> <p>Leadership is important.</p> <p>Senior managers' performance is important; they should be well informed of what is going on to have an overall positive impact on identification.</p> <p>This is highly important.</p> <p>Support from management is important.</p> <p>Accountability of line managers is important—their performance should also be measured to ensure they are accountable for Aboriginal programs.</p> <p>We're nowhere near it currently.</p> <p>Important in making sure their staff are asking the question.</p> <p>Very high, without them you have no support and you need them to help back the AHLO up.</p>
<p>System enhancements: mandatory fields, removal of default values of 'Not-Aboriginal' from registration systems</p>	<p>Would be good to see a system enhancement that allows an Aboriginal individual to identify but opt-out of the AHLO being notified or involved.</p> <p>System enhancements are important and easy to implement.</p> <p>System enhancements are highly important.</p> <p>System enhancements are valuable but not if staff are non-compliant.</p> <p>Removal of the default to 'Not Indigenous' was significant.</p> <p>System enhancements are important to ensure staff member is not able to ignore question until it is asked.</p> <p>Once information is entered, it needs to be re-checked. An Aboriginal person may choose to identify in some instances and not in others.</p> <p>System enhancements are important and likely to have a positive impact if default is removed. It forces staff to ask the question.</p> <p>Question might not be asked by staff if it's not a mandatory field in the system.</p> <p>Compatibility and integration between different systems are highly important.</p> <p>When systems are changed, years of data can be lost.</p> <p>System enhancements increase efficiency and consistency in asking the question.</p> <p>Removal of the option of 'not known' status on online death registration system.</p>



Guidelines need to be established, however their effectiveness are difficult to measure.

Good to have but I'm not sure if these Guidelines are effective.

Guidelines are more likely to impact positively if they are available electronically and matched with training.

I haven't seen these guidelines.

Reports need to be made user friendly; summarising key points rather than a lengthy report.

National Best Practice Guidelines re Identification is a good platform, however, not in terms of practicality.

National Best practice guidelines likely to have a low impact in terms of putting it into practice.

I[f] they get used.

National Best Practice Guidelines are important to organisations to refer to, however, the Koori culture and community varies in different parts of the country therefore it shouldn't be a standard document for all regions.

Haven't seen these.

Haven't seen the guidelines.

Government guidelines are an effective resource that can be taken to management to argue for policy change.

How utilised is the question. If it's not utilised it's just another document.

There are other better practices than the development of a National Best Practice Guidelines for the improvement of Aboriginal identification.

Anything to improve identification is a priority. We need statistics.

Development of National Best Practice Guidelines re Identification

Very important not only for identification but also for promoting a culturally-safe environment. Including the Aboriginal flag.

Unsure if the use of materials to encourage identification has a positive or negative effect. Aboriginal people may wonder why they need to identify, why information is relevant and what it is used for.

Materials encouraging Indigenous people to identify are likely to help patients understand the importance of identifying.

Materials encouraging Indigenous people to identify are important to support the collection of accurate data and consequently to provide better services to the Aboriginal community.

Social marketing is important for achieving accurate identification (e.g. DVDs or other paraphernalia to promote health services, the care and services provided. This may be helpful for community understanding and improving negative perceptions).

Materials should be developed at a community and organisational level. They need to be updated too.

Service specific posters likely to have a positive impact. It is pointless providing specific Aboriginal services if Aboriginal individuals don't declare their status and if the community is not aware of why they should identify. Posters should have artwork and promote a safe environment for Aboriginal people in the health service.

Initiatives such as posters are important.

Very important—help patients understand why it's important to identify.

I am not sure if materials used to encourage Indigenous people to identify are important. Staff members are likely to remove posters and pamphlets at point of admission. Although it's important for the community to see photos of community members, in the end [it's] all about how the question is asked and the knowledge of the person answering.

This hospital has taken the initiative to produce materials outside the ICAP program and without added burden on the AHLO.

Resources are particularly important in the intimidating emergency department. Aboriginal patients are drawn to the colours.

If you put up a poster, make sure it says the right things.

Very useful—jolt the memory of staff.

We haven't got posters at this hospital. But they will soon be available.

The community responds to images they recognise. Artwork creates an inviting environment and posters help break the barriers by acting as a reminder to staff to ask the question.

It would be better if resources went directly to services for service enhancements. Services should be provided with printed hard copies rather than electronic versions that they need to invest in printing.

Materials encouraging Indigenous people to identify (posters and pamphlets at point of admission)



Community-based visits to communicate why the information is collected and how it is used	<p>How do you get to people not using community-controlled organisations?</p> <p>These haven't happened directly but when the community has been involved, it has been effective.</p> <p>Communicating why the information is collected and how it is used may be perceived in a negative way and may not get Indigenous people to identify. Identifying Indigenous status is a personal choice.</p> <p>Members of the community are still very suspicious of the government and therefore uneasy about providing information.</p> <p>Community-based visits to communicate why the information is collected and how it is used may have some impact only if a good relationship between services is available.</p> <p>This happens one-on-one in the community.</p> <p>Social marketing is important for achieving accurate identification.</p> <p>Information must be presented back to the community in an appropriate format.</p> <p>Community-based visits can have a positive impact and help community understand why the information is collected and how it is used.</p> <p>This may be beneficial in helping people to understand why identification is important and how data is used.</p> <p>An [AHLO's] work in a community is not specifically about identification, however, their connection to the community is very important generally.</p> <p>Oral health promotion at youth festivals and schools encourage identification. Hospital newsletter and radio recording also provides information on what services are provided at this hospital.</p> <p>The reasons why the information is collected are already known by the community. How we share information between the hospital and the community is more important.</p> <p>Community based visits could be done by the department, not the AHLO.</p> <p>Communication with the community is important; relationships are mediated via conversations (the phone is often sufficient once the relationship is formed).</p>
Strengthened relationships between health service and local community-controlled organisation	<p>More needs to be done with social marketing through the Aboriginal community to promote the hospital as a safe place to be, provide information on hospital services and strategies to improve care for Aboriginal patients, and inform Aboriginal patients what they have the right to expect and what to do if their expectations are not met.</p> <p>The relationship is likely to be of medium importance since accurate identification has been observed in hospitals that lack an Aboriginal Community Organisation.</p> <p>Invest and maintain dialogue and commitment between agencies/services.</p> <p>If there are good relationships between community and health services then maybe, but for most hospitals no. This would not be a priority for improving identification.</p> <p>This is one of the premises of ICAP; strengthened relationships between hospitals and ACCHOs are important for ensuring overall success.</p> <p>Strong relationships between health services and local community-controlled organisations are important to support each other.</p> <p>Community Controlled Organisations are in a good position to inform people prior to a hospital visit; some referrals come through these organisations.</p> <p>The Health Service must form a partnership with General Practitioners through referrals. The hospital can't do it alone.</p> <p>Relationships exist but we need the right people at the table.</p> <p>Aboriginal oral health group quarterly meetings have been important in strengthening relationships.</p> <p>Patients can be referred to specific teams and other health organisations, therefore strong relationships between the health service and local community-controlled organisations are of some importance.</p>



<p>Routine feedback provided by government to health services and community organisations using the data collected</p>	<p>This is an important indicator of Aboriginal people's access to mainstream acute health services and can prompt the need for improved patient identification strategies and inform service planning.</p> <p>Audits and <i>Koori Health Counts</i> reports are an important routine feedback mechanism.</p> <p>Feedback to organisations is critical. Really sell the point that health services can't offer a service to a community if they don't identify the community.</p> <p>Routine feedback is important. The community is critical that nothing useful is done with the data collected.</p> <p>Routine feedback provided by the government has an impact on identification since it allows the hospital to benchmark against the performance of other hospitals on key indicators.</p> <p>Data provided by the Department does not go deep enough to be useful for an individual service. Health services should [make] use of their own data to enable deeper analysis and research, which should always be fed back to the community.</p> <p>Feedback is important, AHLOs and hospitals are very interested in data. Data should be provided to stakeholders regarding what the data are showing. It is also important that the government is transparent in relation to the data collected when communicating with the community.</p> <p>Information needs to be owned in partnership with the community.</p> <p>Routine feedback is important to communicate to the community results obtained from collected data.</p> <p>The regional DHS/Health rep provides the AHLO with information when requested.</p> <p>Feedback to the community is highly important and a lot of information seems to be collected. More feedback from the government is needed.</p> <p>Analysis provided by the Department does not go deep enough to be useful for an individual service. In addition, services are likely to object to their performance being publically scrutinised in great detail. Health services should [make] use of their own data to perform deeper analysis and research into local issues. Data should be used to start conversations within the health service.</p> <p>As long as it's done in the right way and data is used appropriately.</p> <p><i>Koori Health Counts</i> is a useful document which enable[s] the hospital to see itself as part of a bigger picture.</p> <p>The <i>Koori Health Counts</i> reports are useful.</p> <p>The co-op is unlikely to be interested in this information.</p> <p>Make sure the information is relevant and a true indication of what is happening.</p> <p>We need more of it. Had more hope with the AHLO data and <i>Koori Health Counts</i> reports, which were brilliant. It was good to have in hard copy, helps benchmarking with other hospitals for chronic conditions.</p> <p>Routine feedback when provided by government is highly important.</p> <p>BDM should not do any community profiling—it is appropriate to give data back in other circumstances.</p>
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Site-based Aboriginal-specific health clinics	<p>Site-based Aboriginal-specific health clinics are likely be beneficial, however, they're not critical for Aboriginal patient identification.</p> <p>Impact of site-based Aboriginal-specific health clinics depend on entry to hospital:</p> <ul style="list-style-type: none"> • bypass hospital directly to clinic (lower impact due to no effect on hospitals datasets) • entry through hospital (higher impact since referral to a clinic leads to identification [of] the person's status at hospital). <p>The clinic in itself would increase exposure but importance would depend on how it's used.</p> <p>Koori Midwifery clinic is an initiative funded by this hospital, which provides culturally sensitive and woman-focused care to Aboriginal women.</p> <p>Site-based Aboriginal-specific health clinics are important, however [it's] more important for an Aboriginal person to have a choice where they access care. Appropriate care should be provided in every instance, not just in some service with a certain proportion of Aboriginal patients accessing them.</p> <p>Site-based Aboriginal-specific health clinics not as effective as the model of care tailored to Aboriginal community.</p> <p>Data collection might end up focusing on information obtained from site-based Aboriginal specific health clinics. Integration is better than segmentation.</p> <p>Site-based Aboriginal-specific health clinics are important for encouraging identification (e.g. the presence of barriers such as shame factor and community fall-out may discourage willingness to identify in a general health clinic).</p> <p>Site-based Aboriginal-specific health clinics provide easy entry into a big organisation for specific clients. These services help build trust and good rapport with patients which is good for quality of care, but it's debatable how effective they are in terms of identification in the hospital more broadly.</p> <p>Aboriginal-specific clinics may actually be a deterrent to identification when a patient doesn't want Aboriginal staff to know their business.</p> <p>Yes, Indigenous people more likely to identify and a lot of site-based Aboriginal-specific health clinics are now asking for proof of identification.</p> <p>E.g. VAHS. Cultural safety—offers choice.</p> <p>No comment.</p> <p>Workers (Koori maternal nurses, in home workers, coop nurses, MCH [maternal and child health nurses, and preschool support officers) assist parents complete the birth registration forms. Children can only be enrolled in schools if birth certificate is provided. Children's official name and date of birth must be used to access their VIC student number.</p>
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Local Hospital Circulars reinforcing the importance of identification.

Quarterly reporting of data to hospital CEOs for benchmarking; including summary of the WIES loading, increases/decreases in the proportion of patients identified and a summary of all hospitals in the same category.

There is a need for greater transparency and health service account[ability] around WIES funding, as indicated in the recent review of the ICAP /KMHLO programs. Reporting of Aboriginal patient numbers and WIES loading has just been introduced into the Department of Health's Program Report for Integrated Service Monitoring (PRISM), which is tabled with health service CEOs quarterly.

All members of the organisation should be pushing the agenda. Aboriginal identification is everyone's responsibility, not only the [AHLO's] duty.

Employment of Aboriginal staff in all areas (e.g. Receptionist, cleaners, cooks, clinical roles etc).

Need to create a mechanism to target the data collectors. Call all registration staff together and talk to them. Routine processes will get lost if there isn't a feedback loop back to those collecting the data.

Idea: Identification information on waiting room televisions in GP [General Practitioner] surgeries— 'if you're Aboriginal, get up and tell reception'.

Idea: Encourage community to identify on community radio e.g. 'Deadly Health' and 'The Hump'.

Any effort to promote self-identification and create a link with the community will strengthen identification.

VAED Country of birth & Indigenous Status system flag.

Some 'closing the gap' funds have been made available to Victorian hospitals to implement the strategic directions outlined in the ICAP Review. Projects funded include, social marketing strategies (flags, artwork, posters DVDs), fixed term employment opportunities for specific projects and enhancement of internal policies and strategies.

Other

Training should be provided for Medical Records students in universities.

Important for aboriginal people to know how important the information is and how it is used.

People asking the question and those being asked must understand why the information is needed, otherwise fear of stigmatisation might prevent identification.

GPs play an important role. They should be identifying patients for their own service delivery. They should pass this information on when referring to hospital and inform the patient that they will [b]e asked about their Aboriginality.

Support and encourage Aboriginal careers in health.

Information on what to expect in the ED [Emergency Department]. This could include an indication of current wait times in the waiting area e.g. "Current wait times are approximately..." Information about other options would also be helpful. For example, a list of other 24hr clinics. Volunteers in the ED having a chat could ease anxiety and pass the time for some.

Cultural safety is important. Each individual ha[s] their own perception of a cultural safe environment.

Link the importance of recording Indigenous status to the delivery of quality care inside/ outside the hospital.

Proper partnerships, more programs, more Indigenous people at the table to invest the WIES dollars (senior management have a lot of priorities).

A specified Aboriginal Health Unit including a strategy person, monitoring the data and developing policies and bouncing ideas.

Information on the ICAP site.

Making the question mandatory, although this is not commonly known.



Question 5: What do you consider to have been the most effective initiatives/policies implemented to improve Indigenous identification in hospitals and/or birth and death registrations since 1980?

The first column contains initiatives arising from thematic analysis of informant responses. The second column contains responses relating to the theme.

Themes	Informants responses to Question 5 sorted by theme
AHLOs and Aboriginal staff	<p>AHLO positions.</p> <p>The presence of AHLOs has increased staff awareness, in addition to formal training and other cultural activities.</p> <p>Aboriginal Hospital Liaison Officers.</p> <p>The employment of AHLOs.</p> <p>AHLO roles.</p> <p>AHLOs active on the ground within hospitals. These roles have a positive impact and ensuring Aboriginal patients not identified at registration are picked-up later.</p> <p>Introduction of the AHLO Program in the 1980's, and the continued growth in the number of Liaison roles today.</p> <p>Aboriginal Hospital Liaison Officers.</p> <p>AHLOs were vital to getting Aboriginal data on the agenda, with the support the DoH provided.</p> <p>The Koori midwife role. Word of mouth means women now offer their Aboriginal status and ask for the Koori midwife.</p> <p>Birth: Indigenous identification in hospital Aboriginal liaison officers. (e.g. The RWH [Royal Women's Hospital] Indigenous women's unit—staff worked hard to ensure that Indigenous women were identified and offered the services provided by the unit).</p> <p>The work of [AHLOs], initially in the early days... at the Children's hospital has since spread out into all aspects of health.</p> <p>AHLOs.</p> <p>The employment of AHLOs has been the most effective initiative at this hospital.</p> <p>AHLOs in hospitals.</p> <p>The presence of Aboriginal staff in mainstream hospitals helps increase the awareness and importance of the question being asked.</p> <p>Employment of a Koori Customer Service Officer.</p> <p>AHLO meetings to discuss what else can be done to get better identification.</p> <p>Establishment of Aboriginal-identified roles in government agencies (with VCAT [Victorian Civil and Administrative Tribunal] exemptions) and the broadening of Aboriginal-specific Units across government and Senior Aboriginal people.</p>
The ICAP program	<p>An overarching aim of The ICAP Program is to improve Aboriginal identification. The program has been an effective initiative, to get Aboriginal identification back on the agenda.</p> <p>The WIES copayment and ICAP program have been effective at making Aboriginal health and identification the hospital[s] responsibility rather than the Department of Health's responsibility.</p> <p>ICAP program and all its associated activities.</p> <p>The use of materials/posters through ICAP and having Aboriginal paintings on the wall. These are a talking point.</p> <p>I'm very proud of the ICAP Program. It has created relationships in a national and State level and its success is evidenced by the increase in AHLO numbers.</p> <p>Department of Health Policy on identification (see ICAP resources kit).</p>



Staff training	<p>Training is of paramount importance. Training should be ongoing.</p> <p>The AHLO presentation at staff orientation has made a difference with some staff. It's too open and not in-depth though.</p> <p>Training for staff, particularly nursing staff.</p> <p>Registration staff training.</p> <p>Staff training and Identification workshops at this hospital.</p> <p>Education for medical students.</p> <p>General Practitioner education programs.</p> <p>Education programs for midwifery students and handouts on how to ask the question.</p> <p>Staff training.</p> <p>Specific training for midwives.</p> <p>Education for student doctors and midwives.</p> <p>Training data collectors why and how the question should be asked.</p> <p>Regular education sessions conducted for staff by the hospital.</p> <p>Linking identification with finance e.g. WIES loading. Other initiatives are also important, such as staff training and system enhancements. When change is system-wide, and when Administrators are driving change, it signals behavior.</p> <p>Cross-cultural training is important for understanding why asking the question is important.</p> <p>Cross cultural training.</p> <p>Continuous education of data collectors: ongoing due to turnover of staff.</p> <p>Cross cultural training in the hospital—it would be better with two people and not solely relying on the AHLO.</p> <p>Cultural competency training. It's important for training to be ongoing due to staff turnover in agency.</p> <p>Staff training/Identification workshops provided by the hospital.</p> <p>Educating ward clerks and emergency staff. The AHLO needs to know Aboriginal patients are in the hospital.</p> <p>Targeting admission clerks rather than midwives regarding the importance of asking the question when booking women for antenatal care and birth (often by phone).</p> <p>Ensuring asking the question was imbedded in the culture of the hospital, that all staff knows the importance of the question to the provision of care, and everyone is asked at the first contact with the hospital.</p>
Aboriginal flags and artwork	<p>Flags outside health services—patients go where they see the flag.</p> <p>Posters, artwork and flags have made a difference.</p> <p>The use of materials/posters through ICAP and having Aboriginal paintings on the wall. These are a talking point.</p> <p>Flags outside the hospital and paintings make the hospital an inviting and friendly environment for Aboriginal people.</p> <p>Resources for the community including magnets and posters.</p>
Promotional materials	<p>Identity posters and fliers.</p> <p>Promotional materials/identity posters for all settings: hospitals, general practice, funeral directors.</p> <p>The use of materials/posters through ICAP and having Aboriginal paintings on the wall. These are a talking point.</p> <p>Local hospital circulars generating interest.</p>



Hospital Aboriginal WIES supplement	<p>VAED Aboriginal and Torres Strait Islander WIES Supplement.</p> <p>The WIES copayment and ICAP program have been effective at making Aboriginal health and identification the hospital[']s responsibility rather than the Department of Health's responsibility.</p> <p>Linking identification with finance e.g. WIES loading. Other initiatives are also important, such as staff training and system enhancements. When change is system-wide, and when Administrators are driving change, it signals behavior.</p> <p>WIES loading: it was an overall driver to improve identification and with that came compliance/reporting requirements.</p> <p>The VAED WIES loading; hospitals talk in dollars.</p> <p>Processes for holding the hospital accountable, for example the WIES dollars and accreditation.</p>
System enhancements and data improvements	<p>Introduction of mandatory identification of Aboriginal status.</p> <p>Systems: 1994 standardisation of admission forms. Changes to coding were a barrier to identification when the #2 code changed to Torres Strait Islander.</p> <p>Introduction of the variable to record the Indigenous status of the baby in perinatal data.</p> <p>Including the identification question for the baby in Perinatal records.</p> <p>Removal of default to 'not Indigenous' so that staff at registration don't take it upon themselves to make a decision.</p> <p>Linking identification with finance e.g. WIES loading. Other initiatives are also important, such as staff training and system enhancements. When change is system-wide, and when Administrators are driving change, it signals behavior.</p> <p>Expanding to record the Indigenous status of the baby in 2009 to capture the status of the father of the baby as well as the mother.</p> <p>Data quality improvement procedures at BDM.</p> <p>Removal of 'not stated' option.</p> <p>Introduction of the Indigenous status question to VAED</p> <p>Introduction of a variable to record the Indigenous status of the baby in the perinatal collection is likely to be an effective initiative.</p> <p>Recording of the Aboriginality of the baby in the perinatal system to capture babies born to Aboriginal fathers/non-Aboriginal mothers.</p>
Government bodies, coordination and key initiatives	<p>The Victorian Aboriginal Affairs Taskforce.</p> <p>Whole of government coordination and approach to Aboriginal affairs including: Senior Officers Group, Secretary's Group and Aboriginal Affairs Taskforce. The social determinants play an important role in health.</p> <p>Communication between all people in the sector with the aim of improving Indigenous identification.</p> <p>The 'Closing the Gap' campaign.</p> <p>The Indigenous Access Program and resulting Indigenous Access Fund (re RBDM).</p> <p>Establishment of Justice Service Centres (re RBDM).</p> <p>Practice Incentives Program (PIP) is a good initiative but could be better. Pharmaceuticals are free or low cost, however, the GP needs to be registered and hospital pharmacies are not eligible for the service.</p> <p>Closing the Gap initiatives: These initiatives created awareness and engaged people to take Indigenous identification on board. They have also increased people's interest and involvement in Aboriginal Health.</p>



Data validation	<p>Koori Health Counts publications have been a valuable source of data for public hospitals and tool for comparing performance with peers.</p> <p>Cross-referencing data from the hospital system with Perinatal data.</p> <p>Efforts of the Department and hospitals to review and assess the credibility of data and the Department's reporting back numbers through the Koori Health Counts publications.</p> <p>Cross-checking between AHLO, Perinatal and VAED data; AHLO data was assumed to be the most accurate, but it did not cover all hospitals.</p> <p>Local benchmarking against Closing the Gap targets and benchmarking against other hospitals on key indicators.</p>
Accountability and accreditation	<p>Health services required to report on indicators relating to Indigenous health through Quality of Care Reports.</p> <p>Processes for holding the hospital accountable, for example the WIES dollars and accreditation.</p>
Community engagement and education	<p>Community engagement—telling community what services are on offer for them at the hospital.</p> <p>Community education outlining why identification is important, how the collected data is used.</p> <p>Resources for the community including magnets and posters.</p>
Other	<p>It's difficult to rank efforts. It takes time and depends on the development of trust between the community and people in government regarding why/how the information will be used.</p> <p>The issue needs a full frontal approach in all directions. There was a significant level of mistrust in the past.</p> <p>I believe that the staff are able to arrange for Indigenous status to be corrected at the hospital level.</p> <p>Who knows? It hasn't been monitored properly.</p> <p>Clinics within hospitals.</p>



Question 6: Do you know if there have been any evaluations of these initiatives or evidence of effectiveness?

Informants' responses to this question are listed separately for local and State-wide activity.

Local evaluation activity

A number of health services have used data to support business cases to justify AHLO roles, whereby substantial increases in numbers of identified Aboriginal patients have coincided with the appointment of AHLOs.

Local benchmarking against Closing the Gap targets.

Through the partnership with the ACCHO, the health service can evaluate if it has really made a difference and identify what indicators should be focused on in the future.

Evaluation of cross cultural training at the health service has indicated that staff are more comfortable asking the question and numbers of Aboriginal patients being identified have been increasing.

Training appeared to be effective at this hospital. The number of identified patients tripled, departments have requested repeat training and participant feedback forms were very positive.

Ongoing evaluation of staff roles.

Hospital accreditation highlighted the importance of the AHLOs' role in facilitating access to services.

State-wide evaluation activity

Participant evaluations from Aboriginal patient identification training sessions.

Ongoing review of numbers of identified patients in the VAED/VEMD.

Emergency Department project evaluation.

Aboriginal Health Promotion and Chronic Care (AHPACC).

Koori Maternity Services evaluation.

AIHW [hospital Indigenous identification] audits in 2007 and 2011.

The ICAP Program has been evaluated and reported to have shown some improvement in rates of identification. There is room for more improvement to be made regarding Aboriginal people self-identifying, staff asking the question and whether there has been an increase in the number of Aboriginal people visiting hospitals.

In 1992–1993 and 2000–2001: the Research and Liaison Midwife conducted (at least) two validations of the Perinatal data to evaluate improvement of Indigenous identification.

2002: 'Looking at Identification of patients in hospitals': Evaluation of the identification process conducted by Onemda and La Trobe, a precursor to the increase in WIES co-payment loading from 10% to 30%.

2009 Road Show: There was an internal report regarding locations visited and services provided with the Indigenous Access Program.



Question 7: Do you believe any events or factors outside the health system impact on an Aboriginal person's willingness to identify?

The first column contains initiatives arising from thematic analysis of informant responses. The second column contains the number of responses that related to this theme. The third column contains these responses.

Factor	No. of times mentioned	Informants' responses
Interaction with, or fear of interaction with, government agencies and programs	21	<p>Existing trust issues with government agencies.</p> <p>Previous/current interaction with government agencies, e.g. if having problems with housing, or having been in trouble as an Aboriginal person anywhere else like child protection or juvenile justice.</p> <p>All policies of government have an impact including personal and familial contact with police, housing, child protection etc.</p> <p>Distrust of government due to personal experiences.</p> <p>Pauline Hanson's 1996 maiden speech to the House of Representatives and the NT Intervention are likely to have had a negative impact on an Aboriginal person's willingness to identify.</p> <p>Willingness to identify is not just about the health system it's tied up with experiences with housing, education etc.</p> <p>If a person is a member of the Stolen Generation [they] may not wish to identify due to a fear of hospitals (due to intervention in the past and child protection).</p> <p>Some patients come into hospital with complex issues involving other services (e.g. DHS & children removal).</p> <p>Some patients are unsure why the information is being collected and fear external agencies will be contacted (e.g. 'They're going to call the Police on me').</p> <p>Experience with housing and employment agencies.</p> <p>Personal experiences (e.g. whether the person was removed or adopted as a child).</p> <p>Past treatment from organisations such as Centrelink and housing whereby people are fobbed off so many times that they don't bother anymore.</p> <p>Fear of interaction with other services such as housing, the police, and Centrelink. This may lead to individual choosing to identify in some places but not others.</p> <p>Acknowledgment of ownership of land—the local Council partnership with the Wurrunjerrri people.</p> <p>The Aboriginal Justice Agreement, Direct Service Agreements and work of Aboriginal Planning Officers.</p> <p>Public sector jobs and Aboriginal community organisations possibly led to a greater willingness to identify.</p> <p>Empowerment and entitlement through the development of the Recognised Aboriginal Parties (RAP) in Victoria.</p> <p>Respect in the community through Council , Local Government Area (LGA) and Health service activities.</p> <p>Under Closing the Gap they said that they would need Aboriginal people employed by mainstream services, but with GPs they didn't exempt the positions.</p> <p>Past history of 'racist' treatment from Government institutions.</p> <p>Census time.</p>



Government policies, e.g. child removal	11	<p>Past Government practices likely to have caused a negative impact on an Aboriginal person's willingness to identify.</p> <p>Older individuals might fear identifying as Aboriginal from past experiences (e.g. Stolen Generation).</p> <p>The Stolen Generations continue to impact current beliefs and behavior. This is the reality of their childhood, it's not distant history. The belief that if I identify, my kids will be taken away.</p> <p>The experiences of the Stolen Generation may have an impact on an Aboriginal person's willingness to identify due to a perceived threat from government.</p> <p>Historical government policies are still impacting on people today, passed through generations through story telling (only 4–5 generations).</p> <p>Aboriginal people becoming Australian citizens only in 1967.</p> <p>The 'Half Caste policy'; legislation telling people whether they are Aboriginal or not by the colour of their skin.</p> <p>Community conflict, previous racism and history.</p> <p>The Stolen Generation.</p> <p>A fear of children being taken away as per the past.</p> <p>Political climate at the time.</p>
The National Apology	11	<p>Positive news stories outside the health system like the Apology.</p> <p>The 'Apology': people felt better about being an Aboriginal patient, but I'm not sure if it had an impact on an Aboriginal person's willingness to identify.</p> <p>The 'Apology'.</p> <p>The 'Apology' had an impact; however, not much happened after it.</p> <p>The 'Sorry' statement is likely to have had a positive impact.</p> <p>The apology is likely to have had an impact on both Aboriginal and non-Aboriginal people.</p> <p>The 'Sorry statement' is unlikely to have had an impact on practical levels; however, it has created a platform to work from, increasing support and engagement with the Department of Health (e.g. Closing the Gap, inclusion of Aboriginal health on the agenda and more people in the Department engaged with improving Aboriginal health).</p> <p>The Apology: It is easy to say 'Sorry' but real actions have not been shown since. This is the community's point of view.</p> <p>The 'Sorry' statement is unlikely to have had an impact. People need to see action rather than more rhetoric.</p> <p>The 'Apology': people felt better about being an Aboriginal patient, but I'm not sure if it had an impact on an Aboriginal person's willingness to identify.</p> <p>The 'Apology' and 'Closing the Gap' initiatives may have had a greater impact on the non-Aboriginal population than on the Aboriginal community.</p>



Cultural safety within health services	10	<p>A perception that identification may lead to stigmatisation in some sense, of getting singled out from the rest of the community. Judged as a poor parent because they're Aboriginal.</p> <p>A willingness to identify relies on an individual's sense of safety.</p> <p>Experiencing prejudice: patients may fear they will be treated differently/ discriminated or singled out if they identify.</p> <p>Racist preferences in services.</p> <p>Flying the Aboriginal Flag and posters—cultural safety.</p> <p>Flying the Aboriginal flag.</p> <p>Familiar faces fronting health promotional campaigns might have a positive impact on identification.</p> <p>Who's asking the question? It should be more of a Koori to Koori interaction to get around issues of trust.</p> <p>Unwelcoming environment likely to have a negative impact on person's willingness to identify.</p> <p>Community events hosted by a health service helps promote the service and give back to the community (e.g. Christmas BBQ, Kids presents from Santa). This enables [health] service staff to engage with the community at a grass roots level. The local council can get involved, staff can volunteer, and a community member's experience with the service is likely to impact on their willingness to return.</p>
Media reports	9	<p>Media reporting on Aboriginal crime—stereotyping.</p> <p>Aboriginal health is in the limelight, which may impact on an Aboriginal person's willingness to identify.</p> <p>Aboriginal health is a current political issue.</p> <p>Negative comments in the media.</p> <p>Media reports regarding Indigenous issues (positive and negative).</p> <p>Pauline Hanson's 1996 maiden speech to the House of Representatives and the NT Intervention are likely to have had a negative impact on an Aboriginal person's willingness to identify.</p> <p>Negative material in the media can impact an Aboriginal person's willingness to identify and is likely to affect staff members in health services who may consequently have a more aggressive approach towards Indigenous patients.</p> <p>'Closing the Gap' initiatives may have had a greater impact on the non-Aboriginal population than on the Aboriginal community.</p> <p>The overall increase in awareness makes people feel more comfortable and gives them an assurance that they won't be treated differently.</p>
Racism and social stigma	6	<p>The broader social climate including periodic shifts in public expressions of racism, which dictates whether people feel comfortable talking about Aboriginality. An open social climate makes people feel less 'at risk'.</p> <p>Plethora of negative experiences of racism outside the health system.</p> <p>Social stigma: due to perceived disadvantage and fear of negative treatment.</p> <p>Racist comments.</p> <p>Racism is a big factor.</p> <p>Community conflict, previous racism and history.</p>
Senses of pride or grief/helplessness	5	<p>Cultural heritage and increasing pride in culture/heritage.</p> <p>Growth in community pride e.g. Football and netball teams.</p> <p>A person's strength in their identity.</p> <p>It is sometimes difficult for an Aboriginal woman to feel comfortable and being proud of who they are.</p> <p>Grief and a state of helplessness is likely to influence an Aboriginal person's willingness to identify.</p>



Education	4	<p>School education regarding Indigenous Australia likely to have an impact on person's willingness to identify (e.g. How it is taught, if at all).</p> <p>Health education—understanding the health system.</p> <p>Social determinants (e.g. housing and social factors).</p> <p>Institute of Koorie Education at Deakin University has returned positive results. It helps build people's self-esteem.</p>
Family experiences and storytelling	4	<p>History [is] often passed on verbally in this population and therefore the beliefs and experiences of grandmothers and mothers are passed down to women, particularly first time mums.</p> <p>Historical government policies are still impacting on people today, passed through generations through story telling (only 4–5 generations).</p> <p>Previous experiences of the emergency department personally and within the community are likely to have an impact since people's beliefs are shared verbally between individuals in the community.</p> <p>Family group are likely to be influencing each other's likelihood of identifying based on individual experiences and understanding of benefits to identifying, impact on care and accessibility.</p>
Community conflict	3	<p>Community conflict, previous racism and history.</p> <p>An Aboriginal person might not wish to identify due to a community conflict with an AHLO.</p> <p>Koori health services may not be chosen for use due to community fall-out, which may also lead to an unwillingness and fear of identifying.</p>
Other	7	<p>There are likely to be many and varied influences and incidents in an individual's life (positive and negative) impacting on whether a person discloses their Aboriginality.</p> <p>Aboriginal people are encouraged to identify their child at birth to enable them to participate in ACCHO programs and services.</p> <p>Messages from Aboriginal leaders e.g. Pat Dodson's public resignation from his founding chairmanship of the Council for Aboriginal Reconciliation in 1977 due to disillusionment and loss of faith. This sent out a big message to the community.</p> <p>Aboriginal patients may get insulted if asked /not asked the identification question e.g. 'You're not Aboriginal are you?'</p> <p>An individual's perception of the broader health system and health profession.</p> <p>If a patient has mental health or drug and alcohol issues, they are unlikely to identify.</p> <p>Travel money and time: services may be readily available, however travel time and money can act as barriers to accessing services.</p>



Question 8: Where do you think future policy should focus to achieve improved identification?

In the following two tables each cell represents the response/s of one informant. Responses have been sorted into the two informant groups.

Policy/government/academic group responses

It's important to acknowledge that everything being done now should be continued and much more.

Fund technical system improvements to efficiently improve the quality/integrity of the data in records at BDM.

Build a capacity in the Register to allow for subsequent identification to capture the changing propensity to identify.

How can we increase the willingness to identify? My reasons for not identifying might be different from yours.

The national definition (constituting self identification, heritage and community recognition) is problematic for birth and death records where identification is provided by a third party (parent, next of kin or other source e.g. hospital record) at the point of registering an event.

Regular training of admission staff.

Employment of Aboriginal staff in a variety of roles (AHLOs, non-clinical positions, executive positions, support roles, case management, out-patient follow up).

Social marketing.

System focus to ensure software efficiency and accurately prompting staff to ask the question at different points throughout the care of the patient.

Provision of data to hospitals, feedback mechanism.

Board level accountability.

Sharing good practice (examples in ICAP resource kit).

Quality improvement process, ongoing review of all aspects (see St Vincent's Toolkit).

Internal reports: analysis of data.

Hospital processes for certifying death records.

Emergency department focus since staff members more likely to be unable to ask or patient unable to answer the question.

Aboriginal health should be prioritised in each hospital and included in the organisation's vision and business planning.

Long term: changing the mainstream to respect Aboriginal culture.

Short term: hammer the admission clerks, Aboriginal organisations and hospital Chief Financial Officers (re WIES).

Future policy should focus on the accurate estimation of indigenous status.

Diminish funding focused on training staff members to ask the Indigenous question, particularly in areas where the proportion of Aboriginal population is small compared to the total population.

Focus on admission clerks, potentially introduce an incentive for achieving correct identification. Focus on the first point of contact with the health service to result in solid collection of information.

Increase the numbers of Koori midwives also due to trust, understanding cultural factors and capitalising on positive word of mouth in the community. Women will talk to each other about which midwives are good, which hospitals they feel comfortable in.

Policies should focus on how data are used. Record linkage is a useful technique to collect extra information and has the potential to support improvements in identification.

AHLOs provide strong links between community services and mainstream hospital services and could be useful in ensuring patients are identified at some stage.



Improving the social determinants of health to help people get to a position where they have good self-esteem. Those with the greatest reticence are those with the greatest fear of the system, low SES.

Encouraging involvement in society and community, improving diet and exercise and thus decreasing chronic illness and increasing health and self-esteem.

Ongoing scrutiny of the data by the Health Department, hospital by hospital.

Do we have enough AHLOs in Victoria? If not, what's the shortfall? Answers to these questions will dictate whether additional investment is valid.

With the National Health and Hospital Reforms, the Casemix model will be reviewed. The Indigenous loading may or may not be adopted nationwide; which may have an impact on identification.

Social Marketing to ensure government is trusted by the community leading to self-identifying.

National Guidelines.

IT [information technology] System changes.

Must get other stuff right before the policies have a big impact (such as the trust issues). Policies are important to achieve improved identification, however, the practical stuff makes the biggest difference.

Idealistic: Be clear about why identification is important. Demonstrate this by reporting data back to the community, helping them understand where the data goes and why it is useful and how it can benefit the community.

Process: Change management process in health services. Managerial support and training for staff to ask the question in the right manner to avoid making a person feel threatened by the question.

Institutional change management: Start in one institution and get it right before implementing across the State. Break down the processes to identify where the problem is, and once the source/s are identified, it is easier to address the problem.

Just targeting one thing doesn't work. We need systematic, sustainable change within health services. All hospital staff, Aboriginal and non-Aboriginal should be involved and accountable. Currently, if a Project Officer walks out the door, the project falls down.

More local education.

Societal change.

Accreditation is a valuable tool; Aboriginal indicators must remain part of the EQUiP [Evaluation and Quality Improvement Program] accreditation framework.

A feedback loop to services and communities about what is known from the data; the Victorian hospital sector doesn't receive sufficient collated information about their Aboriginal patients.

Ensure ongoing support/resources for hospitals to deliver quality of care outcomes e.g. AHLOs.

Future policies should focus on ongoing positive messages to highlight the importance of identification in communities.

Terminology: Consistency and clarification of the term 'Indigenous' to avoid confusion and registration of Indigenous people originating from other countries.

Greater resources to deliver more staff training.

More work with funeral director to highlight the importance of asking the question and to clarify that just because the death is not being coordinated by the Aboriginal Funeral Service, it doesn't mean the deceased is not Aboriginal.

Ongoing passion and commitment. Sensitise key staff in all areas about the importance of information.

Presentation of data in appropriate format for distribution/ use within Indigenous communities

Routine validation between datasets is a practical way to assess identification.

Ongoing education of staff members responsible for the collection of Aboriginality data.



ALO/hospital staff group responses

Greater validation and an appropriate level of analysis of data at the Department of Health end. This will encourage hospitals to take it more seriously too.

Education and training: staff training and education for the community.

Inconsistency between datasets is a major issue. National and State dataset consistency should be a priority to achieve improved identification.

Staff training and social marketing:

- to provide staff with cultural understanding and empower them to explain why the question is being asked
- to promote awareness amongst staff of the importance of identifying, which may lead to an improved hospital experience for Aboriginal clients.

(re future training: ask staff members to identify Indigenous identification barriers they believe are present and what initiatives should be introduced for further improvement).

ICAP should continue to be supported, including AHLOs.

Promotional materials to encourage Aboriginal people to identify.

Hospital resources: Hospitals should be accountable for the WIES loading received and use it to make people comfortable to identify if they are finding it difficult to do so, to acknowledge culture and address equity and the human right to health.

This question should be asked of the AHLO at each hospital to determine what would be most effective at that site. In this hospital:

- More posters and Aboriginal artwork around the hospital.
- More advertising for staff about why the question should be asked of every patient, where the data goes, and that the hospital needs it to get the WIES it deserves.

Ongoing training is more important for data collection staff than education is for the community, since they are already aware of why they are asked the question.

Aboriginal-related policies should be more open to the people. A willingness to identify is linked to how people feel about policy, as they shape the community.

Ensure a holistic first point of contact.

Housing is the number one social factor that should be focused on to consequently improve identification.

The existing work at this hospital should be continued into the future including the specialist clinics.

To close the gap in health, policy should focus on improvements to the social determinants such as housing, employment and education.

Higher education: increase the representation of Aboriginal workers in the health system.

Many initiatives are required so that if a person is missed in one they can be picked up in another.

At least one AHLO should be recruited at each hospital site. Some sites need more than one AHLO.

Education for the community via the co-op regarding the basics of hospital processes, reinforcement that patients will get the support of an AHLO if they identify, what to do if they experience racism in the hospital and who to talk to about it. Feeling persecuted is a barrier to future identification.

A short online training program for Victoria would be a great addition to face-to-face training. Medical staff are required to partake in online training for other clinical competencies. The video could include a number of Aboriginal leaders sharing their stories from communities across the State. Some AHLOs don't feel comfortable delivering training and this resource could pick up those people not attending formal sessions.

It would be useful if AHLOs had a contact within the Health Department that they could go to discuss issues at a site level, where they could assess the issue and potential[ly] speak to management.



Clarify WIES with others in addition to senior management:

- report to the Liaison Officer how WIES dollars are spent—involve those doing the job—AHLOs need to know.
- clarify if WIES is supposed to be reinvested to improve services for Aboriginal patients.

The level of Indigenous engagement in hospital-wide policy and procedures. AHLOs should be included as senior management in Closing the Gap partnership talks.

Staff training delivered by DHS and the Koorie Heritage Trust in collaboration with the AHLO:

To help staff understand why the question is asked and how to respond to patients.

Emphasising the link between the questions and the services/treatment made available to the patient in hospital and after discharge. A second question should follow: 'Do you want assistance from the Liaison Officer or another worker?'

The program should include modules on cultural awareness for specific areas (such as ED [Emergency Department], wards, extended care, day patient, and allied health).

Indigenous trainee positions with proper employment opportunities and clear guidelines, (Aboriginal Employment Strategies & Equal Opportunity Act).

Support for Liaison Officers to get over cultural barriers in the hospital.

Support systems to access services.

Making mainstream services family friendly to encourage the whole family getting treatment at the same time.

Counselling services: to encourage people to prioritise their oral health.

Educating the next generation why the question is asked:

More money should be spent on getting the message out in the community. A school program should be funded; the youth can educate mums and dads.

Health Services need to know about services e.g. The Aboriginal Funeral Service and referrals.

Focus on educating the younger generation to facilitate transition. We need more services for Aboriginal people e.g. kindergartens and learning centres. These need to be self-owned and operated.

Fast track Aboriginal patients through the emergency department – they won't wait 8 hours and will leave without treatment – they don't understand the system; that everyone is waiting 8 hours.

Increasing the number of Aboriginal workers in the hospital, including nurses and employment of more AHLOs rather than just one looking after multiple sites.

A culturally-sensitive space allocated in the hospital which can be used for debriefing families, holding meetings between the AHLO and patients.

Supervisors need to be culturally aware and understand the need for debriefing. The AHLO carries a significant burden and needs support.

Education for staff on why the question must be asked and how it improves the service you can provide your patients.

Education for community on what impact identifying will have on them and their community, what happened to the information and how it influences change.

A system enhancement to allow the patient to identify but opt out of AHLO involvement.

Financial incentives work but are they the right thing to do? (e.g. \$30 to attend... health checks or a plasma TV raffle, subsidised pharmaceuticals). It's questionable whether these patients follow-up with future appointments or comply with treatments, and it's only likely to be an incentive for low SES that need the money.

Incentives may assist in getting individuals to do a health check, however still uncertainty on whether patients follow up.



In the hospital birthing unit:

- Ensure the question is asked at the time of booking, usually on the telephone
- Make sure the question is asked in a respectful manner
- Reinforce that the question is asked of everyone
- Support the role of the Koori midwife, women will be more comfortable with their own people
- Ensure the delivery of culturally sensitive woman-focused care.

As the numbers of KHLOs [Koori Mental Health Liaison Officers] has increased over the years and given the community knowledge that [KHLOs] generally have, I think it would help if they received training (if they don't already) about the importance of correct Indigenous identification in hospital datasets.

A gap persists in staff training. Nothing eventuated from the 2007 DHS staff training pilot. A sustainable training package is required that includes:

- Online resources
- Train the trainer model
- Links to further information
- Starting point for cultural competency.

Consistency in datasets.

A feedback loop from the State to services is likely to have a positive impact. The health service can perform internal data analysis and benchmarking, however, comparisons State-wide would be beneficial; 'how did we perform?' If we have the data, we should be using it to determine what we are aspiring to and what the numbers mean.

Focus on a stronger Aboriginal health workforce and partnership with education.

Accountability of General Practitioners: some GPs don't want to do the 'closing the gap' initiatives.

You need to get line managers involved for it to happen.



Question 9: Who do you believe are the key stakeholders for engagement in efforts to improve identification in birth, death and hospital data?

The first column lists the key stakeholder groups provided by investigators in the questionnaire. The second column lists informants' comments supporting their selection of level of importance.

Key stakeholders	Key stakeholders
Data collection staff (e.g. hospital registration staff, midwives, funeral directors, death certificate certifying medical practitioners)	<p>The person collecting the data makes a big difference.</p> <p>Staff have the capacity to influence or be a barrier to identification.</p> <p>Most important.</p> <p>Very important.</p> <p>Everyone is important.</p> <p>Data collection staff are very important.</p> <p>Note clinician's role in death certification in hospitals.</p> <p>Data collection staff likely to be more important for areas with a significant number of Indigenous people.</p> <p>Management has a higher importance than data collection staff; if there is a lack of interest from management, nothing will get done.</p> <p>Important but we can't rely solely on them.</p> <p>They should always check the system for prior admission responses and ensure identification is recorded.</p> <p>Funeral directors and midwives must get it right.</p> <p>GPs are important to target.</p>
Senior health service management (e.g. hospital CEO and Chief Finance Officer)	<p>Important for getting policy pushed through.</p> <p>Sign off on WIES and accreditation/performance reports.</p> <p>Senior health service management are not directly involved in the front line so are less important.</p> <p>Aboriginal people should be a part of the decision making process (e.g. Aboriginal staff should be present at meetings and Senior Management should report back to AHLOs re decisions made and investment).</p>
Managers of data collection staff	<p>Senior health service managers provide direction and support from top down.</p> <p>Direct influence on staff therefore important.</p> <p>Have the capacity to influence or be a barrier.</p> <p>Managers can demonstrate 'this is how we identify the Koori community'.</p> <p>Include the finance department.</p> <p>Important to ensure data collection is happening.</p>
Hospital Health Information Managers	<p>Hospital health information managers are unlikely to be important for future engagement.</p> <p>Important for setting up computer systems and forms.</p> <p>Health Information Managers interact with staff members collecting the data.</p> <p>Health Information managers are important in generating reports and monitoring indicators.</p> <p>Too late in the process.</p> <p>Engage Health Information Managers in the process and use of the data.</p> <p>HIM [Health Information Manager] support to improve data collection is invaluable.</p> <p>Knowledge on how status is recorded on the system.</p>



Aboriginal Liaison Officers	<p>AHLOs are important for advocating and supporting patients and also supporting the hospital to work with the patient.</p> <p>Emphasis should be taken off AHLOs re identification, [it's] other people['s] job.</p> <p>AHLOs are already engaged with the issues.</p> <p>It's not the [AHLO's] role to collect the data but they do play a role in encouraging and supporting staff to ask the question.</p> <p>Aboriginal Liaison Officers have little policy power.</p> <p>Definitely.</p> <p>AHLOs are very important and should be community-based people as AHLOs are known and can effect positively on identification.</p> <p>AHLOs are import[ant] stakeholders through performing audits and reinforcing the importance of identification within the hospital.</p> <p>Education should not be the [AHLO's] role, their role is to support patients.</p> <p>Consistency between two.</p>
Aboriginal Community Controlled Organisations	<p>ACCHOs can play a role in raising awareness among the Aboriginal community about the importance of identifying as Aboriginal within health services.</p> <p>ACCHOs are important in promoting understanding in the community.</p> <p>Word of mouth messages 'make sure you identify in hospital because...'</p> <p>External organisations may have an impact on convincing individuals to be proactive about identifying.</p> <p>They have a role in distributing information to clients and explaining that the question might be asked in hospital and why.</p> <p>Most Aboriginal Community Controlled Organisations employees are Koori.</p> <p>What have they got to share?</p> <p>If they are engaged with other organisations but not on their own specifically to improve identification.</p> <p>Aboriginal Community Controlled Organisations have little control on what information is collected outside their environment.</p>
Data custodians (State government managers of datasets)	<p>Data custodians need to do their job, however they are unlikely to have a high impact when compared to front line staff.</p> <p>Data custodians are already engaged.</p> <p>A feedback mechanism is required to provide information/factsheets back to hospitals in a useful form.</p> <p>Data custodians provide support to hospitals by providing data to enable benchmarking.</p> <p>If custodians provided data analysis, yes.</p> <p>Data custodians provide feedback, therefore very important.</p> <p>Data custodians need to be clear on the identification process and be culturally competent.</p> <p>If they strengthened their analysis of data.</p>
State government: Aboriginal health policy makers	<p>Ensure ongoing commitment to improved identification and Aboriginal health across government, linking in with social determinants.</p> <p>These stakeholders are important internally within government, particularly for making each other accountable, but not directly to individual health services.</p> <p>Policy makers are very important and are partly responsible for the presence of the issue of Indigenous identification.</p> <p>Both Aboriginal Health and overall health system policy makers have a role to play in improving identification, but also in supporting and engaging with the community to consequently have an impact on identification.</p> <p>All important.</p> <p>Operators at ground level.</p>



State government: overall health system policy makers	<p>Overall health system policy makers are important for driving systems and effective processes at the other end.</p> <p>If Aboriginal health is important to these people, then something will happen.</p> <p>Aboriginal health policy makers are important in taking action and driving policy.</p> <p>These stakeholders are important internally within government, particularly for making each other accountable, but not directly to individual health services.</p> <p>Health system policy makers are more likely to have an impact when there are issues or negative results.</p> <p>Policy makers are very important and are partly responsible for the presence of the issue of Indigenous identification.</p> <p>Both Aboriginal Health and overall health system policy makers have a role to play in improving identification, but also in supporting and engaging with the community to consequently have an impact on identification.</p> <p>All important.</p>
Federal government	<p>Federal government accesses some of the data.</p> <p>Depends on department, department of Health and Aging as opposed to Department of Transport.</p> <p>The Federal government important as has a role to play in General Practice (e.g. health checks).</p> <p>General Practitioners and Federal government agencies are important supporters of the narrative.</p> <p>'Closing the Gap' has been a good catalyst in the region.</p> <p>Commonwealth allocates funding to Victoria.</p> <p>AIHW provides useful reports for hospital managers.</p> <p>These stakeholders are important internally within government, particularly for making each other accountable, but not directly to individual health services.</p> <p>They are the ones who can drive policy.</p> <p>Let's see a Koori PM [Prime Minister]!</p> <p>The Federal government has a role to play in implementing systems and ensuring accountability of hospitals.</p> <p>Federal government is a key stakeholder in funding Closing the Gap initiatives e.g. New Directions.</p> <p>COAG driving the agenda and funds, however unlikely to translate to service level.</p>
Other	<p>All stakeholders' roles likely to be highly important for engagement in efforts to improve identification. Individuals' roles vary according to their location and responsibilities. Stakeholders would vary according to system.</p>



Question 10: If you could choose one initiative to fund/introduce/expand to improve identification in Victoria what would it be?

The first column contains initiatives arising from thematic analysis of informant responses. The second column contains these responses relating to the theme.

Initiative/policy	Informants' responses
Education and training	<p>Creating a generic data improvement training package for registration staff that hospitals can deliver themselves. Unless it becomes a part of core business, part of the training agenda, it will be missed. People/agencies outside the hospital don't have the resources to deliver training all the time. The package should be a general data quality training program, with an element of Indigenous data and identification. It should not be promoted as an Aboriginal-specific program in an effort to improve attendance.</p> <p>Simplification of systems so that it isn't a daunting task:</p> <ul style="list-style-type: none"> • Make it routine. • Ensure staff know why question must be asked so that they don't need to convince themselves to ask it. • Education should be ongoing. <p>Concentrate on Admission Clerks as the first point of data collection and extrapolate to the birthing system.</p> <p>Staff training should be supported State-wide to reduce duplicated effort and build on the Best Practice Guidelines. It must be sustainable.</p> <p>Cross-cultural training:</p> <ul style="list-style-type: none"> • Support to health services to deliver ongoing cross cultural training • Try to do a big 'one day' training program for staff. <p>'It's ok to ask the question' – Cultural respect training for registration staff and medical students.</p> <p>Continuous and compulsory cultural training for data collection staff and major support service employees.</p> <ul style="list-style-type: none"> • question is likely not be answered if it is not asked by a staff member • training should be compulsory and part of the employment process • training should be made compulsory for all staff by government if they want to Close the Gap. <p>Education and training:</p> <ul style="list-style-type: none"> • Start at University not when a person starts at a health service job. • Staff member's awareness of the importance of asking the question as well as ensuring it is part of their job routine. • Education should be based on Aboriginal health outcomes, life expectancy, quality of care rather than numbers and data. Highlight how these issues can affect future generations. • Make the Aboriginal community feel comfortable in identifying. <p>Education/oral health promotion: Educating patients why it is important to identify, access services and get treatment. Early intervention is important as many patients currently getting treatment are of a young age.</p> <p>Educating the next generation of youth why the question is asked.</p> <p>Education/training:</p> <ul style="list-style-type: none"> • Cultural awareness should be a part of the curriculum for health professionals (e.g. Nursing and social work) and training should be continued in the hospital. This training should not be done by the AHLO, there are people qualified to deliver training • Staff should be trained re communicating with Aboriginal patients by avoiding medical terminology and using lay terms during discussions with and about them. • It's all about money—this should be funded across the State.



AHLOs and Aboriginal staff	<p>Short term: expand the AHLO program to cover all hospitals.</p> <p>Continue Aboriginal Hospital Liaison Officer roles and expand if there is an identified shortfall and scope to do so.</p> <p>Expanding, supporting and sustaining the role of Indigenous liaison officers in hospitals (that includes training about the reasons for/importance of correct ascertainment of Indigenous status).</p> <p>Aboriginal-identified policy/strategic roles in hospitals to influence policies and procedures at an organisational level. This could include an Aboriginal Health portfolio, not just an AHLO role. Aboriginal health should be a standing agenda item at the board level and committee meetings. The senior policy role could report to the board to influence change.</p> <p>There [are] many important initiatives, however, if I was to choose one it would be Aboriginal Liaison and Koori Midwife roles. Their presence in this hospital has resulted in positive word of mouth in the community.</p> <p>Continue to support and fund AHLOs.</p> <p>Continue to fund AHLOs.</p> <p>Aboriginal mental health workers. We are not currently funded to see any mental health or drug/alcohol patients at all and we need expertise to deal with these complex cases.</p> <p>A full Aboriginal unit in the hospital including:</p> <ul style="list-style-type: none"> • more than one AHLO • an Aboriginal staff member in the team to set policies, processes, and cultural awareness • a strategic role to address issues from an Aboriginal perspective (including hospital accreditation).
Data analysis and validation	<p>Further research aiming to estimate under identification rates.</p> <p>Capturing subsequent changes in identification over time to reflect an individual's willingness to identify over the life course and get a truer picture of the number of Indigenous people there are in Vic.</p> <p>Validation of existing systems/data would be easy to implement electronically and could yield a high return.</p> <p>Funding should focus on data quality analysis and validation of the VAED at the Department of Health end. Greater validation and an appropriate level of analysis of data provided by the Department to hospitals is likely to encourage hospitals to take it more seriously too.</p>
System change	<p>A health service and system focus rather than data focus: Focus on identification of Aboriginality as a means of improving quality of care for Aboriginal patients (e.g. appropriate internal referrals and effective discharge planning) rather than as a data collection activity. Reward managers for accurate data and reward institutions with accreditation.</p> <p>System change:</p> <ul style="list-style-type: none"> • Fund hospitals to respond to the EQulP [Evaluation and Quality Improvement Program] Accreditation. • Supply hospitals with a tool kit and training for staff members (see the St Vincent's Hospital training module—sourced from the ICAP Resources Kit). <p>System change—a framework that ensures:</p> <ul style="list-style-type: none"> • cultural safety • cultural ease • cultural competency, and • cultural awareness.



Partnerships	<p>Commitment to ongoing development of partnerships between:</p> <ul style="list-style-type: none"> • Aboriginal healthcare providers • Aboriginal communities • Universities • Government <p>If you don't have these partnerships, you can't achieve anything else.</p> <p>Policy should focus on initiatives that interact/partner with the community, such as supporting VACCHO and AHLOs to work in health services, to identify key adverse health outcomes. First we need to understand what difference it will make if we know who is, and who isn't Aboriginal. We need to know from community leaders, what do they want to get out of this? Will accurate identification actually dilute adverse outcomes? To collect data accurately, we need to know why it is important.</p>
Other	<p>No single activity is enough on its own. Aboriginal patient identification strategies within health services should ideally be comprehensive and regularly reviewed, with a view to continuous quality improvement. They should be linked to broader hospital priorities and planning processes, and be supported by:</p> <ul style="list-style-type: none"> • effective Aboriginal patient data collection tools, policies, protocols and reporting; • the employment of Aboriginal staff; • a rolling program of regular staff training and education; • Aboriginal patient identification posters; and • Awareness raising within the Aboriginal community. <p>There are too many crucial initiatives to choose one. However, initiatives should be supported over a longer term, not short-term solutions.</p> <p>Reporting back to the community demonstrating how and why the data are used.</p> <p>Paintings and posters throughout this hospital.</p>







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