Australian Healthcare and Hospitals Association

Prototype customised South Australian institutional racism measuring and monitoring tool

Health Performance Council, South Australia

22/8/19

Jane Austin
Director
Health Performance Council (HPC) Secretariat

Unit 6, 60 Hindmarsh Square
Adelaide SA 5000

PO Box 3246
Rundle Mall SA 5000

P: [redacted]

E: [redacted]

W: www.hpcsa.com.au

Australian Healthcare and Hospitals Association

Unit 8, 2 Phipps Close
Deakin ACT 2600

PO Box 78
Deakin West ACT 2600

P: 02 6162 0780

F: 02 6162 0779

E: admin@ahha.asn.au

W: ahha.asn.au

@AusHealthcare

facebook.com/AusHealthcare

linkedin.com/company/australian-healthcare-&-hospitals-association

ABN: 49 008 528 470

Table of Contents

Introduction **1**

Prototype Matrix **3**

Appendix 1 .... **14**

Appendix 2 .... **15**

Matrix history **17**

Glossary **20**

References **21**

Introduction

Australian Healthcare & Hospitals Association (AHHA) presents a prototype customised South Australian institutional racism measuring and monitoring tool to the Health Performance Council South Australia (HPC SA). The prototype is the result of a series of consultations with stakeholders and an expert workshop. It is proposed that this will be the first phase of the co-design and implementation of a customised tool to measure and monitor institutional racism in South Australian hospital and health services.

HPC worked proactively with AHHA to identify relevant stakeholders for the engagement process, including those who were available during the project timeframes. AHHA actively participated in the shared governance of the project including the ethics approval application.

Pre-consultation: HPC and AHHA successfully consulted to identify stakeholders but it was not possible to find a suitable Aboriginal organisation to partner in this project. AHHA undertook teleconferences and face to face meetings with the identified stakeholders to stimulate interest and build engagement. These pre-workshop conversations fostered an awareness of institutional racism, built interest in the project and provided insights that supported the development of a productive agenda for the expert workshop.

Pre-consultations	Stakeholders
23 April 2019	**Professor Alex Brown**, Aboriginal Research Program Leader, South Australian Health and Medical Research Institute (SAHMRI)
9 May 2019	**Aboriginal Health Leaders Forum**, Taoundi College
1 & 2 July 2019	**Dr Tamara Mackean,** Flinders University **Deb Lee** & **Michelle Robinson**, Adelaide Primary Health Network **Cathy Leane** & **Kaylene Kerdel**, Women's and Children's Local Health Network **Kurt Towers**, Northern Adelaide Local Health Network **Tosh Kelly** & **Donna Quinn**, Riverland Hospital, Berri (teleconference) **Shane Mohor**, CEO, Aboriginal Health Council of South Australia **Tanya McGregor**, Director, Aboriginal Health Strategy, SA Health
15 & 16 July 2019	**Mark Chilvers**, Executive Director, South Australian Dental Service **Dr Roger Thomas**, Commissioner for Aboriginal Engagement **Kirstie Parker,** Director of Aboriginal Affairs and Reconciliation, Department of the Premier and Cabinet **Nerida Saunders**, Executive Director of Aboriginal Affairs and Reconciliation, Department of the Premier and Cabinet **Dr Chris McGowan,** Chief Executive, SA Health **Dr Alison Russell**, SA Health **Cindy Pardekooper,** SA Health **Barrie Moyle**, former Chair of the Naracoorte Area Health Advisory Council (teleconference)
19 July 2019	**Zell Dodd,** Chief Executive Officer, Ceduna Koonibba Aboriginal Health Service (teleconference)
2 August 2019	**Dr Kali Hayward,** former President Australian Indigenous Doctors Association (teleconference)

Expert Workshop: HPC, with AHHA confirmation, arranged a one-day expert workshop in Adelaide with identified health management experts to jurisdictionally nuance the Queensland institutional racism matrix for the South Australian context. The workshop was led by AHHA consultants who prepared briefing papers and presentations to inform the workshop. Over the course of the day, the experts were familiarised with

the concepts that form the basis of institutional racism measurement and then actively co-designed an adaptation of the Queensland Health matrix [Appendix 3] to measure institutional racism within South Australia's ten Local Health Networks (LHNs). The focus was on the selection of criteria and associated sub-criteria that would most accurately reflect the structure, governance, policy and administrative arrangements of the LHNs. The Matrix was amended on screen in the workshop in real time, with the amendments accepted by the experts. The scoring of criteria, and sub-criteria, was not fully addressed by the experts; there was a consensus at the workshop that the consultants should complete the scoring for the prototype given that further workshops would be needed for validation prior to implementation.

Attendance at expert workshop 8 August 2019	
Zell Dodd	CEO, Ceduna Koonibba Aboriginal Health Service
Dr Kali Hayward	Former President, Australian Indigenous Doctors Association
Arrin Hazelbane	Office of the Commissioner for Aboriginal Children and Young People
Tosh Kelly	Health consumer and member of Country Health Aboriginal Experts by Experience
Cathy Leane	Women's and Children's LHN
Tanya McGregor	Director, Aboriginal Health Strategy, SA Health
Dr Tamara Mackean	Flinders University
Amanda Mitchell	CEO, Aboriginal Health Council of South Australia
Kim Morey	Manager of Knowledge Translation and Exchange, Wardliparingga Aboriginal Research Unit, SAHMRI
Nerida Saunders	Executive Director of Aboriginal Affairs and Reconciliation, Department of the Premier and Cabinet
Kurt Towers	Executive Director Aboriginal Health, Northern Adelaide LHN, Watto Purrunna Aboriginal Health Services
Klynton Wanganeen	CEO, Narungga Nation Aboriginal Corporation
Sonia Waters	Director of Aboriginal Services, AnglicareSA
Dr Chris Bourke	AHHA consultant
Adrian Marrie	AHHA consultant
Andrew Wineberg	HPC SA Secretariat

Prototype development: AHHA took the concepts and feedback, identified through the pre-consultation and the expert workshop, and developed a prototype customised South Australian institutional racism measuring and monitoring tool. This work included scoring of the criteria, their associated sub-criteria, and their weightings.

Next steps: This first phase of prototype development will require a second phase with validation involving Aboriginal health consumers, health professionals (both Aboriginal and non-Aboriginal) and health administrators (both Aboriginal and non-Aboriginal). Based on the input from the validation workshops a customised institutional racism measurement and monitoring tool can then be constructed. Application of the tool will enable the assessment of institutional racism within the ten South Australian local health networks (LHN) and a report on the findings.

Prototype Matrix

The Prototype is presented as a Matrix scored out of 200 points, rather than the original Queensland Health matrix [Appendix 2] of 140; the scoring to denote the different levels of institutional racism has been adjusted accordingly.

The Prototype Matrix is presented here, firstly without annotations to facilitate clarity, and then secondly with annotations to provide detail about information sources, criteria scoring, sub-criteria scoring, and weighting.

The structure of the original Matrix, based on five key indicators, has been retained [see Appendix 1]. These indicators, with minor re-wording, are:

- Participation in LHN governance
- Policy implementation
- Service delivery and partnerships
- Recruitment and employment
- Financial accountability and reporting: Closing the Gap funding

Plain version Prototype Matrix

The un-annotated Matrix Prototype facilitates focus on:

1) the overall structure (based on the five key indicators for detecting institutional racism) and content (the 14 criteria and their associated sub-criteria); and
2) the scoring and the way in which their scores are weighted. This includes an appraisal of the overall balance of the scores.

Prototype Matrix for LHN audits

Prototype customised South Australian institutional racism measuring and monitoring tool

Key Indicators and Criteria	Scoring
1. Participation in LHN governance	
1.1 Good governance	**Total out of 10**
1.1.1 Board interaction with Aboriginal community	2
1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting	2
1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee	2
1.1.4 LHN Board members are educated about Aboriginal health in their LHN	2
1.1.5 LHN Board members receive cultural respect training	2
1.2 Aboriginal representation at board level	**Total out of 10**
1.3 Inclusion in Executive Management Structure	**Total out of 10**
1.3.1 A stand-alone Aboriginal Health Division	5
1.3.2 Aboriginal LHN lead directly reports to the LHN CE	5
Total	**30**
2. Policy implementation	
2.1 Improving Aboriginal Health Outcomes	**Total out of 10**
2.1.1 Explicitly identified as a strategic priority in LHN Strategic Plan	5
2.1.2 Aboriginal health outcome KPIs explicitly referred to in LHN	

	Strategic Plan	5
2.2	**Community engagement**	**Total out of 20**
2.2.1	Aboriginal community consultative body	4
2.2.2	Aboriginal community engagement embedded within overall community engagement strategy	4
2.2.3	LHN Aboriginal community newsletter/e-letter	3
2.2.4	At least one Aboriginal community forum/meeting per year convened by the LHN chief executive	3
2.2.5	Reconciliation Action Plan	3
2.2.6	Aboriginal health professionals caring for patients included within clinical engagement strategy	3
2.3	**Public Reporting and Accountability (via LHN annual report)**	**Total out of 20**
2.3.1	Traditional Owner acknowledgement	1
2.3.2	Improving Aboriginal health outcomes	
	(i) Separate section in report devoted to Aboriginal health	2
	(ii) Reporting on KPIs contained in current service level agreement (SLA)	2
	(iii) Report Aboriginal community engagement	2
	(iv) Report on Aboriginal specific National Safety and Quality Standards assessment	2
2.3.3	Policy references	
	(i) Cultural Learning Framework	1
	(ii) Chronic disease consortium plans	1
	(iii) National Quality and Safety standards	1
	(iv) Aboriginal workforce framework	1
2.3.4	Aboriginal health division/unit placement on LHN organisational structure/chart	1
2.3.5	Data on Aboriginal access to and delivery of services	2
2.3.6	Aboriginal employment	
(i)	Data on Aboriginal employment	2
	(ii) Reference to workforce planning, recruitment, etc.	1
2.3.7	Other recognition (e.g., awards, scholarships, etc.)	1
2.4	**Public Reporting and Accountability (via real time reporting on LHN website)**	**Total out of 20**
2.4.1	Traditional Owner acknowledgement	1
2.4.2	Improving Aboriginal health outcomes	
	(i) Separate section in report devoted to Aboriginal health	2
	(ii) Reporting on KPIs contained in current service level agreement (SLA)	2
2.4.3	Policy references	
	(i) Cultural Learning Framework	2
	(ii) Chronic disease consortium plans	2
	(iii) National Quality and Safety standards	2
	(iv) Aboriginal workforce framework	2
2.4.4	Aboriginal health division/unit placement on LHN organisational structure/chart	1
2.4.5	Data on Aboriginal access to and delivery of services	2
2.4.6	Aboriginal employment	
(ii)	Data on Aboriginal employment	2
	(ii) Reference to workforce planning, recruitment, etc.	1
2.4.7	Other recognition (e.g., awards, scholarships, etc.)	1
	Total	**70**

3. Service delivery and Partnerships

3.1	**Aboriginal LHN Plan**	**Total out of 10**
3.1.1	Co-designed with ACCHO(s) in LHN region	2

3.1.2	Formal agreement with ACCHO(s) in LHN region	2
3.1.3	Commitment to Continuous Quality Improvement	2
3.1.4	Mutually agreed KPIs	2
3.1.5	Clear statement of ACCHO and LHN responsibilities and conflicts	2
3.2	**Cultural safety**	**Total out of 10**
3.2.1	Implementation of cultural safety policy/strategy	5
3.2.2	Proportion of staff trained	5
3.3	**Selected health service performance indicators reported publicly**	**Total out of 20**
3.4.1	Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission	3
3.4.2	Discharges against medical advice (DAMA)	4
3.4.3	Potentially preventable hospitalisations (PPH)	3
3.4.4	Access to mental health services as reported at service level agreement	3
3.4.5	Low birth-weight babies	3
3.4.6	Healthcare outcome differential measures (eg, discharge summary timeliness)	4
	Total	**40**

4. Recruitment and employment

4.1	**Aboriginal health workforce development reporting**	**Total out of 20**
4.1.1	Implementation of Aboriginal workforce strategy	4
4.1.2	LHN KPI for Aboriginal employment	4
4.1.3	Number of Aboriginal health practitioners, health workers and liaison officers	3
4.1.4	Number of identified Aboriginal positions	3
4.1.5	Number of salary bands occupied by Aboriginal employees	3
4.1.6	Number of long-term Aboriginal employees	3
4.2	**Aboriginal participation in the health workforce**	**Total out of 20**
4.2.1	Managerial and clerical	3
4.2.2	Medical including Visiting Medical Officers (VMOs)	4
4.2.3	Nurses	4
4.2.4	Operational and Support Services	3
4.2.5	Trade and Artisans	3
4.2.6	Health Practitioners (Professional and Technical)	3
	Total	**40**

5. Financial Accountability and Reporting: Closing the Gap Funding

	Commonwealth contributions for Aboriginal health programs to LHN	**Total out of 10**
	South Australian contributions to Aboriginal specific health services and programs	**Total out of 10**
5.2.1	Reporting on use of activity-based funding loading for Aboriginal patients	5
5.2.2	Reporting on contributions for Aboriginal specific health services and programs	5
	Total	**20**

Total Score	**200**

Institutional Rating scored against criteria

Score:	**>160**	**130-159**	**100-129**	**70-99**	**40-69**	**<40**
Evidence of Inst. Racism:	**Very Low**	**Low**	**Moderate**	**High**	**Very High**	**Extreme**

© Henrietta Marrie and Adrian Marrie 2019, Bukal Consultancy Services Pty Ltd

Scoring

The Prototype Matrix scoring system is based on five key indicators under which criteria have been assigned that address policy elements relevant to Aboriginal health outcomes. The 14 criteria have an assessment value of either 10 or 20 points to provide a total of 200 points. Most of the criteria have been broken down into sub-criteria.

The scoring system is weighted towards priorities in Commonwealth and South Australian health policy and the input from the expert workshop, otherwise a simple "yes/no" [yes=1; no=0] system would suffice. For example, priority is given to Aboriginal representation in the governance structure of the LHNs. Participation at this level will be a major determinant of both LHN accountability and effectiveness in delivering healthcare services to the Aboriginal community. Participation on the LHN Board and within the executive management structure (through direct membership on the Board, directorate status for Aboriginal health within the divisional structure and hence membership of the executive management team/group, and whether or not the divisional director is an Aboriginal person or not) is a case of "either it exists, or it doesn't", in which case either full points for that criterion/sub-criteria are awarded, or none at all.

This principle applies throughout for scoring against the various criteria and sub-criteria employed in the Prototype Matrix. For example, the criterion 2.2 concerns community engagement. This has been divided into six sub-criteria:

i. an Aboriginal community consultative body [2.2.1 = 4 points];
ii. Aboriginal community engagement is embedded within the overall LHN community engagement strategy [2.2.2 = 4 points];
iii. an LHN Aboriginal community newsletter [2.2.3 = 3 points];
iv. at least one Aboriginal community meeting per year hosted by the LHN CE [2.2.4 =3 points];
v. a Reconciliation Action Plan for the LHN [2.2.5 = 3 points]; and
vi. Aboriginal health professionals caring for patients included within the LHN clinical engagement strategy [2.2.6 = 3 points].

While the criterion for community engagement is weighted at 20 points, achieving the overall score out of 20 will depend on whether the various aspects of community engagement, identified by the sub-criteria, exist or not.

A key purpose for a tool that measures and monitors institutional racism is to encourage public reporting about progress and initiatives undertaken to close the gap in Aboriginal health outcomes. This important information ought to be part of LHN annual reports, it can also be provided on LHN websites and other publicly accessible media.

Public reporting of performance enables accountability for Aboriginal healthcare to the Aboriginal community; a fundamental step to reduce institutional racism. Public reporting also enables transparency, validation and verification of institutional racism measurement. Therefore, Aboriginal health programs and outcomes that are not reported publicly, in a readily accessible manner, cannot be accounted for in measuring institutional racism. This can create tension for health administrators when favourable information, only available within the healthcare organisation, is not counted.

For example, many Queensland Health and Hospital Services [HHSs] received low, or zero scores, for the employment of Aboriginal and Torres Strait Islander people in the Anti-Discrimination Commission Queensland 2017 Report. Whilst all the HHSs employed Aboriginal and Torres Strait Islander people the reporting was very poor in their annual reports. Some provided an overall percentage of the workforce, others a detailed breakdown of their Aboriginal and Torres Strait Islander workforce across employment categories, but most reported nothing at all. The inadequate, or absent, information about Aboriginal and Torres Strait Islander workforce in the HHS annual reports resulted in low or zero scores, even though Aboriginal and Torres Strait Islander people were employed.

Annotated version Prototype Matrix

Prototype Matrix for LHN[1] audits

Prototype customised South Australian institutional racism measuring and monitoring tool

Key Indicators and Criteria	Scoring
1. Participation in LHN governance[2]	
1.1 Good governance[3]	**Total out of 10**
1.1.1 Board interaction with Aboriginal community	2
1.1.2 LHN Aboriginal health performance indicators on Board agenda for every meeting	2
1.1.3 Direct input to Board by LHN Aboriginal Community Consultative Committee	2
1.1.4 LHN Board members are educated about Aboriginal health in their LHN	2
1.1.5 LHN Board members receive cultural respect training	2
1.2 Aboriginal representation at board level[4]	**Total out of 10**
1.3 Inclusion in Executive Management Structure	**Total out of 10**
1.3.1 A stand-alone Aboriginal Health Division[5]	5
1.3.2 Aboriginal LHN lead directly reports to the LHN CE[6]	5
Total	**30**

[1] Each audit begins with a basic description of the LHN including population demographics, size and proportion of the Aboriginal population, traditional custodians, ACCHOs, health services provided, etc.

[2] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.13: Competent governance. This indicator generally addresses matters of competent governance in the delivery of healthcare to Aboriginal people by requiring that the Aboriginal community within an LHN region have representation and agency in the governance structure defined as comprising the board and the executive management group.

[3] The criterion and associated sub-criteria are designed to measure the levels of interaction with the local Aboriginal community including understanding of their particular health issues, that the board is taking an active interest in improving the health of that community by focusing on the LHN's Closing the Gap performance and initiatives based on selected KPIs, and that the non-Aboriginal board members have received cultural respect training. Information concerning the five sub-criteria should form a part of the board's reporting in the LHN's annual report. Absence of such reporting will attract a score of 0 per sub-criterion. Alternatively, if the board publishes summaries of their meetings, scores can be allocated according to the information provided.

[4] Whether the board has Aboriginal representation. Because significant weighting is given to Aboriginal representation in the governance structure the scoring is an "all-or-nothing" basis.

[5] The organisational structure of the LHN should include a stand-alone Division of Aboriginal Health. This division could be responsible for, for example, (i) oversight of Closing the Gap and other Aboriginal health programs and budgets as per the LHN's LSA; (ii) monitoring quality and safety of health service provision to Aboriginal clients; (iii) cultural safety training to the non-Aboriginal LHN workforce; (iv) Aboriginal workforce development; (v) patient liaison services; (vi) intra-LHN interdepartmental liaison; and (vii) external liaison with ACCHOs within the LHN region, including oversight of the Aboriginal LHN plan (criterion 3.1). A stand-alone division with an Aboriginal head would score 5/5. However, should this entity exist at a lower level within the LHN administrative hierarchy, and/or have a non-Aboriginal director, it will attract a lower score. The position/status of this division/unit should be indicated in the organisational chart of the LHN in the annual report (see sub-criterion 2.3.4). The profile of the director should also be given along with the profiles of other executive level staff in the LHN in the annual report.

[6] This sub-criterion reflects the status of the Aboriginal head of the division of Aboriginal health – this person should be a member of the LHN's executive management group.

Footnote continued…

2. Policy implementation[7]

2.1 Improving Aboriginal Health Outcomes		**Total out of 10**
2.1.1	Explicitly identified as a strategic priority in LHN Strategic Plan[8]	5
2.1.2	Aboriginal health outcome KPIs explicitly referred to in LHN Strategic Plan	5
2.2 Community engagement[9]		**Total out of 20**
2.2.1	Aboriginal community consultative body	4
2.2.2	Aboriginal community engagement embedded within overall community engagement strategy[10]	4
2.2.3	LHN Aboriginal community newsletter/e-letter	3
2.2.4	At least one Aboriginal community forum/meeting per year convened by the LHN chief executive	3
2.2.5	Reconciliation Action Plan[11]	3
2.2.6	Aboriginal health professionals caring for patients included within clinical engagement strategy	3
2.3 Public Reporting and Accountability (via LHN annual report)[12]		**Total out of 20**

[7] This criteria is linked to the 2008 COAG *National Partnership Agreement on Closing the Gap in Indigenous Health* Outcomes (NPACGIHO) and *The National Indigenous Reform Agreement* (NIRA) and the suite of policies that the agreements have generated at the state level. Community engagement is also fundamental for the successful implementation of Closing the Gap health policy. However, there must be readily available sources of information to Aboriginal and Torres Strait Islander people for effective community engagement. Such information, in the first instance, should be made available in the LHN annual reports and websites.

[8] The parent documents regarding the LHN strategic plan include the *SA Health Strategic Plan 2017 to 2020* and *SA Health Strategic Plan 2017 to 2020: Early Actions*.

[9] Community engagement occurs through different mechanisms. For example, community consultative committees with membership drawn from the LHN region, a community reference group with membership based on expressions of interest, or an Aboriginal consultative body. A Reconciliation Action Plan might be another mechanism to promote community engagement. Thus, sub-criteria can be established under community engagement, and the points allocated accordingly.

Reference: ATSIHPFPM Tier 3: Health System Performance – 3.13: Competent governance. Effective community engagement is essential to good/competent governance.

This criterion is scored out of 20, with six sub-criteria selected by the expert group to reflect different aspects of LHN engagement with the Aboriginal community. The presence of an Aboriginal community consultative body [2.2.1] should be indicated in the LHN annual report; evidence of the inclusion of mechanisms for Aboriginal community engagement in the community engagement strategy [2.2.2] should be found in the LHN's own publicly available strategy; the LHN Aboriginal community newsletter [2.2.3] should be published on the LHN website; reporting on the Aboriginal community forum/meeting with the LHN CE [2.2.4]could either be reported in the annual report or on the website in the newsletter; the RAP [2.2.5] should exist as a separate published document; and a section given to the inclusion of Aboriginal health professionals caring for patients in the LHN clinical engagement strategy [2.2.6] should appear in the published document.

[10] The following documents are relevant to this sub-criterion: *SA Health Guide for Engaging with Aboriginal People*. Adelaide; the *Consumer and Community Engagement Governance Model – consumer and community advisory groups*; and the *Policy Guideline: Consumer and Community Advisory Committee/ Group (CACAC/CAG) Policy Guideline and Toolkit*.

[11] The RAP should draw on the *Reconciliation Framework for Action 2014-2019*.

[12] Annual reports are the primary documents for institutional public accountability. Information can also be conveyed by regular LHN bulletins, websites, etc. The purpose of this criteria is whether annual reports demonstrate recognition, respect and inclusivity towards the Aboriginal community within each LHN – that the LHN is also "their" health service, operating on their behalf, and delivering healthcare and health services to meet their needs. Traditional Owner acknowledgement, progress on Closing the Gap (e.g., by reporting on national KPIs), Aboriginal health workforce employment data, special achievement – all serve as indicators of how the LHN is respecting and serving the Aboriginal community. Comprehensive and quality information is essential for Aboriginal communities to give informed advice and guidance to their representatives involved in LHN governance.

Reference: ATSIHPFPM Tier 3: Health System Performance – 3.13: Competent governance. LHN public reporting and open disclosure on performance are essential to good/competent governance.

Footnote continued…

2.3.1	Traditional Owner acknowledgement	1
2.3.2	Improving Aboriginal health outcomes	
	(i) Separate section in report devoted to Aboriginal health	2
	(ii) Reporting on KPIs contained in current service level agreement (SLA)	2
	(iii) Report Aboriginal community engagement	2
	(iv) Report on Aboriginal specific National Safety and Quality Standards assessment	2
2.3.3	Policy references	
	(i) Cultural Learning Framework[13]	1
	(ii) Chronic disease consortium plans	1
	(iii) National Quality and Safety standards	1
	(iv) Aboriginal workforce framework[14]	1
2.3.4	Aboriginal health division/unit placement on LHN organisational structure/chart	1
2.3.5	Data on Aboriginal access to and delivery of services	2
2.3.6	Aboriginal employment	
	(iii) Data on Aboriginal employment	2
	(ii) Reference to workforce planning, recruitment, etc.	1
2.3.7	Other recognition (e.g., awards, scholarships, etc.)	1
2.4	**Public Reporting and Accountability (via real time reporting on LHN website)[15]**	**Total out of 20**
2.4.1	Traditional Owner acknowledgement	1
2.4.2	Improving Aboriginal health outcomes	
	(i) Separate section in report devoted to Aboriginal health	2
	(ii) Reporting on KPIs contained in current service level agreement (SLA)	2
2.4.3	Policy references	
	(i) Cultural Learning Framework	2
	(ii) Chronic disease consortium plans	2
	(iii) National Quality and Safety standards	2
	(iv) Aboriginal workforce framework	2
2.4.4	Aboriginal health division/unit placement on LHN organisational structure/chart	1
2.4.5	Data on Aboriginal access to and delivery of services[16]	2
2.4.6	Aboriginal employment	
	(iv) Data on Aboriginal employment	2
	(ii) Reference to workforce planning, recruitment, etc.	1
2.4.7	Other recognition (e.g., awards, scholarships, etc.)	1
	Total	**70**

Scored out of 20, this criterion is broken down into sub-criteria which reflect the kinds of information that should occur in an annual report. For the most part the sub-criteria are marked on the presence or absence of the designation information.

[13] References: *SA Health Aboriginal Cultural Learning Framework* and *SA Health Aboriginal Culture and History Handbook.*

[14] Reference: *SA Health Aboriginal Workforce Framework 2017-2022*.

[15] This criterion and associated sub-criteria cover essentially the same subject matter as the previous criterion, except that the information to be provided would be continuously up-dated on the LHN website.

[16] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.06: Access to hospital procedures; 3.14: Access to services compared with need.

Footnote continued…

3. Service delivery and Partnerships[17]

3.1 Aboriginal LHN Plan[18]		**Total out of 10**
3.1.1	Co-designed with ACCHO(s) in LHN region	2
3.1.2	Formal agreement with ACCHO(s) in LHN region	2
3.1.3	Commitment to Continuous Quality Improvement	2
3.1.4	Mutually agreed KPIs	2
3.1.5	Clear statement of ACCHO and LHN responsibilities and conflicts	2
3.2 Cultural safety[19]		**Total out of 10**

[17] Effective healthcare requires an integrated and coordinated approach between hospitals and Aboriginal community-controlled health service embodied in the co-design of local level health service plans. Effective healthcare for Aboriginal and Torres Strait Islander people depends upon a culturally safe non-Indigenous health workforce. Evidence is sought as to the existence of a cultural safety training plan or strategy, whether the LHN has the capacity to deliver such training, and the percentage of the non-Indigenous workforce who have completed training. To assist in the measurement of service delivery a number of Tier 3 Health System Performance Measures (HSPM) have been selected from the *Aboriginal and Torres Strait Islander Health Performance Framework* endorsed by AHMAC in 2011.

[18] According to the Australian Government Primary Health Care 2009 report:

> The complex, fragmented and often uncoordinated delivery systems that operate across primary health care have implications for the services individuals receive, how they pay for them, and how care providers interact and provide care… [T]he primary health care sector…is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are hard to reach (quoted in Alford, 2014:25).

Most LHNs will also have at least one ACCHO within their area. There may also be separate independent community-controlled facilities for aged care, drug and alcohol rehabilitation, mental health and harm prevention, and child-care/youth services. Also, as Alford (2014: 21), in her report to NACCHO, points out:

> The lack of a coherent Indigenous primary health care policy or strategy and associated funding commitments results in inadequate and poorly distributed government expenditure on Aboriginal health, and in particular on Indigenous-specific, community based and controlled health care services. The predictable result is that **too much money is being spent on hospitals. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care** [original emphasis].

While the policy issues emanate from higher up at the government level, one way of addressing these issues, including government expenditure on Aboriginal health, is at the local level. It is important that public health and Aboriginal health services sectors, and their respective funding allocations, are properly integrated and coordinated in their responsibilities for delivering healthcare for Aboriginal people. This can only be effectively achieved through a co-designed and costed health service plan.

Reference: ATSIHPFPM Tier 3: Health System Performance – 3.17: Regular GP or health service; 3.18 Care planning for chronic diseases. These HPF measures are embodied in the requirement for a health plan to be established between an LHN and the ACCHO(s) that operate within their region to ensure regular and ongoing access to medical treatment after referral or discharge from an LHN facility. Within the context of a plan, many other aspects of effective/appropriate/efficient healthcare delivery can also be more readily addressed, such as antenatal care [3.01]; immunisation [3.02]; health promotion [3.03]; early detection of health conditions and their early treatment [3.04]; and chronic disease management [3.05].

This criterion and associated sub-criteria reflect the essential elements required of an Aboriginal health plan established between an LHN and Aboriginal health and allied services within the LHN region. The presence of absence of these elements will be marked accordingly.

[19] Culturally unsafe healthcare contributes to persistent health inequalities for Aboriginal and Torres Strait Islander people. LHNs will need a coherent set of policies and planning instruments to provide cultural safety and ensure that non-Indigenous staff have been well trained to deliver culturally safe care.

Cultural safety training for non-Indigenous employees within an LHN is a core part of the strategy for Closing the Gap, and for which there is a KPI focusing on:

- the institutional capacity to deliver training; and
- the number of non-Indigenous staff who have participated in or received training.

Footnote continued…

3.2.1	Implementation of cultural safety policy/strategy	5
3.2.2	Proportion of staff trained	5
3.3	**Selected health service performance indicators reported publicly[20]**	**Total out of 20**
3.3.1	Estimated level of completion of Indigenous status – specifically the reporting of 'not stated' on admission[21]	3
3.3.2	Discharges against medical advice (DAMA)[22]	4
3.3.3	Potentially preventable hospitalisations (PPH)[23]	3
3.3.4	Access to mental health services as reported at service level agreement[24]	3
3.3.5	Low birth-weight babies[25]	3
3.3.6	Healthcare outcome differential measures (eg, discharge summary timeliness)	4
	Total	**40**

4. Recruitment and employment[26]

[20] The sub-criteria selected by the expert workshop included health system performance indicators from the *Aboriginal and Torres Strait Islander Health Performance Framework: Health System Performance* (AHMAC, 2012). The Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was designed to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH) and was an important tool in the development of the *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*. The HPF monitors progress in Aboriginal and Torres Strait Islander health outcomes, health system performance and the broader determinants of health. The HPF covers the entire health system, including Indigenous-specific services and programs, and mainstream programs.

The matrix is concerned to measure health system performance particularly from the perspective of Aboriginal and Torres Strait Islander community engagement, LHN accountability and service delivery.

[21] The NHRA, in Schedule B referencing the Independent Hospital Pricing Authority (IHPA), in para. B13 states:

> In determining adjustments to the national efficient price, the IHPA must have regard to legitimate and unavoidable variations in wage costs and other inputs which affect the costs of service delivery, including:
>
> c. patient complexity, including Indigenous status.

While not included as a Tier 3 HSPM, nevertheless, much has been written about the need to improve the rates of Indigenous identification in the healthcare system as a policy imperative. Incomplete and inaccurate identification of the Aboriginal population is commonplace in health administration and clinical information systems in services across Australia. Poor recording of Aboriginal status results in Aboriginal people being recorded as 'non-Indigenous' or 'not stated' within collection systems, and their records not included in monitoring and analysis of health system utilisation and patient outcomes. This in turn under-estimates the burden of disease and service utilisation, underplaying inequalities in health. In addition, it is unknown whether the characteristics of these 'missing' individuals are similar or different to those who are identified as Aboriginal, potentially biasing analysis and reporting. Improving identification rates of Aboriginal people in health services has been prioritised as part of the COAG commitment to Closing the Gap in the NIRA.[21] Queensland Health (QH) has issued *A guide for improving the identification of Aboriginal and Torres Strait Islander people in health care* to support and inform HHS staff so that they can "ensure the care and services they provide are both clinically and culturally responsive." QH uses "Indigenous status – reporting of 'not stated' on admission" to record this data (Marrie 2017:67).

[22] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.09: Discharge against medical advice

[23] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.07: Selected potentially preventable hospital admissions

[24] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.10: Access to mental health services

[25] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.01: Antenatal care; Tier 1: Health Status and Outcomes – Health conditions: 1.01 Low birthweight

[26]The recruitment and employment indicator measures the existence and effectiveness of strategies for recruiting and retaining Aboriginal people into the LHN's workforce against local LHN population equity targets for Aboriginal employment. The primary document, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2011 – 2015,* is informed by health workforce elements within the National Partnership Agreements for Closing the Gap In Indigenous Health Outcomes, Indigenous Early Childhood Development and Indigenous Economic Participation (Marrie 2017: 47).

Footnote continued…

4.1 Aboriginal health workforce development reporting[27]		**Total out of 20**
4.1.1	Implementation of Aboriginal workforce strategy	4
4.1.2	LHN KPI for Aboriginal employment	4
4.1.3	Number of Aboriginal health practitioners, health workers and liaison officers	3
4.1.4	Number of identified Aboriginal positions	3
4.1.5	Number of salary bands occupied by Aboriginal employees	3
4.1.6	Number of long-term Aboriginal employees	3
4.1 Aboriginal participation in the health workforce[28]		**Total out of 20**
4.2.1	Managerial and clerical	3
4.2.2	Medical including Visiting Medical Officers (VMOs)	4
4.2.3	Nurses	4
4.2.4	Operational and Support Services	3
4.2.5	Trade and Artisans	3
4.2.6	Health Practitioners (Professional and Technical)	3
	Total	**40**

5 Financial Accountability and Reporting: Closing the Gap Funding[29]

This indicator is focused on whether there is a published plan or strategy for Aboriginal health workforce development, who has responsibility for ensuring that the plan or strategy is implemented, and the level of Aboriginal employment assessed against the proportion of Aboriginal people of the total population in the local LHN region. It is also important to record where Aboriginal people are being employed within an LHN and at what level. Whilst employment percentages can be impressive, many Aboriginal people may be employed in clerical positions and in support services (as cleaners, bed washers, patient transporters, etc) and not in front line services as doctors, nurses or other health professions. Aboriginal health practitioners, health workers and liaison officers have important roles within LHNs and should be separately identified.

Reference: ATSIHPFPM Tier 3: Health System Performance – 3.12: Aboriginal and Torres Strait Islander people in the health workforce.

[27] Reference: ATSIHPFPM Tier 3: Health System Performance – 3.22: Recruitment and retention of staff

[28] Aboriginal and Torres Strait Islander health workforce are a key part of providing culturally safe healthcare for Aboriginal and Torres Strait Islander clients. The number or percentage of Aboriginal people employed within each of the 6 employment streams should be published in each LHN annual report, and the classification level at which they are employed within the following three categories:

- Executive and Senior Officer roles: CEO, SES, SO1 and SO2 positions
- Middle Manager roles: AO6, AO7 and AO8 positions, or their equivalent.
- Lower Level roles: AO2- AO5 positions.

Queensland Health's *Aboriginal and Torres Strait Islander Health Worker Career Structure* (revised 2009) (p. 8) provides the classification structure detailing level, title and minimum qualifications for Indigenous Health Workers which might correspond with the above classification levels.

Additional weighting is given to those employment streams that provide clinical and frontline services.

This criterion addresses Tier 3 HSPM 3.12 "Aboriginal and Torres Strait Islander people in the health workforce" under the heading "Responsive".

Reference: ATSIHPFPM Tier 3: Health System Performance – 3.20: Aboriginal and Torres Strait Islander peoples training for health-related disciplines.

[29] In *The Report of the National Commission of Audit* (2014), it is pointed out that transparency and accountability "are the hallmarks of responsible government." In a general summation of the problems regarding Commonwealth public sector accountability and performance, the National Commission of Audit notes that:

> The availability of good information on the performance of government programmes and activities is crucial to ensuring taxpayers funds are well spent and government is held to account. … Current arrangements make it difficult for the community to determine whether money is well spent, whether spending programmes meet their objectives and how efficiently and effectively the public sector is performing.

Footnote continued…

Commonwealth contributions for Aboriginal health programs to LHN[30]		**Total out of 10**
South Australian contributions to Aboriginal specific health services and programs[31]		**Total out of 10**
5.2.1	Reporting on use of activity-based funding loading for Aboriginal patients	5
5.2.2	Reporting on contributions for Aboriginal specific health services and programs	5
	Total	**20**

Total Score	**200**

Institutional Rating scored against criteria

Score:	**>160**	**130-159**	**100-129**	**70-99**	**40-69**	**<40**
Evidence of Inst. Racism:	**Very Low**	**Low**	**Moderate**	**High**	**Very High**	**Extreme**

© Henrietta Marrie and Adrian Marrie 2019, Bukal Consultancy Services Pty Ltd

---

The Implementation Plan 2007-2013 for the *National Strategic Framework for Aboriginal and Torres Strait Islander Health*, proposes:

> Increased reciprocity of information between governments, providers and consumers of Aboriginal and Torres Strait Islander health services.

As an immediate priority action, one of the specific strategies is to: "Improve accountability requirements of funded organisations…" Another action to improve accountability is by: "Including in funding agreements for mainstream services (where applicable) an accountability requirement for improving outcomes for Indigenous Australians through mainstream and specific programs." (DoHA 2007, p. 43). However, Alford notes that there is still a lack of balance in government funding on Indigenous primary health care expenditure:

> Too much money is being spent on hospitals [compared to Aboriginal Community Controlled Health services as more effective providers of primary health care]. Government funding issues include rationing Aboriginal health expenditure, under-utilisation of mainstream services, mainstreaming Indigenous expenditure, false economies resulting in avoidable and expensive hospital usage, sustainability and reporting issues, and failure to distribute funding equitably by a coherent, transparent, formal process. **Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services. Yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half (48.4%) of all expenditure is on hospitals** (ROGS E 2012 Table 5.2). Maldistribution of funding adversely impacts on services and clients, in New South Wales, Tasmania and Queensland severely, and Victoria considerably.

Financial accountability in Aboriginal and Torres Strait Islander health is extremely important. Aboriginal and Torres Strait Islander people, as well as the community at large, want, and have a right, to know how the money is spent on programs targeted to Aboriginal and Torres Strait Islander health. Financial Statements within annual reporting requirements should include, as part of their income-expenditure reporting, separate statements regarding funding specifically allocated to Aboriginal healthcare and service delivery (either through federal or state allocations) or through special grants programs – for example, for clinical trials, NHMRC grants, allied health services (ATODS, Mental Health, Dialysis), employment and training under Closing the Gap funding. Sub-criteria could be added to reflect local/regional funding circumstances (Marrie 2017: 48-9).

Reference: ATSIHPFPM Tier 3: Health System Performance – 3.21: Expenditure on Aboriginal and Torres Strait Islander health compared to need

[30] Data on Commonwealth expenditure on Aboriginal health within the public health system is exceedingly difficult to find, partly because it is derived from different programs, and is not delivered as a consolidated amount. However, LHNs should be able to identify these sources and quantify the funds received.

[31] As with the Commonwealth, there appears to be a reluctance to disclose sources and amounts of funding received for the diverse array of Aboriginal health programs. An example of funding disclosure in Queensland is provided by the Torres and Cape Hospital and Health Service in the *Annual Report 2016-17*, p. 19. However, the table identifying 20 funded programs totaling $9,092,382 does not fully identify whether the sources are Commonwealth or state, or joint contribution.

Appendix 1

MATRIX TEMPLATE

13 Point Matrix for identifying, measuring and monitoring Institutional Racism within Public Hospitals and Health Services (H and A Marrie, 2014)

Key Indicators and Criteria	Scoring	Score
1. Participation in organization leadership/governance		
• Legal visibility in relevant health service legislation	20	?
• Aboriginal and Torres Strait Islander representation at health service board level	10	?
• Inclusion in Executive Management structure	10	?
Total	**40**	**?**
2. Policy implementation		
• Closing the Gap in Aboriginal and Torres Strait Islander health outcomes	10	?
• Community engagement	10	?
• Public Reporting and Accountability in annual reports	10	?
Total	**30**	**?**
3. **Service delivery**		
• Aboriginal and Torres Strait Islander Health Service Plan	10	?
• Cultural competence	10	?
• Selected Health Service Performance Indicators	10	?
Total	**30**	**?**
4. **Recruitment and employment**		
• Aboriginal and Torres Strait Islander health workforce development	10	?
• Aboriginal and Torres Strait Islander participation in health workforce	10	?
Total	**20**	**?**
5. Financial Accountability and Reporting: Closing the Gap Funding		
• Commonwealth contribution	10	?
• State/Territory contribution	10	?
Total	**20**	**?**
Score	**140**	**?**

Institutional Rating scored against criteria

Score:	**>110**	**80-109**	**60-79**	**40-59**	**20-39**	**<20**
Evidence of Inst. Racism:	**Very Low**	**Low**	**Moderate**	**High**	**Very High**	**Extreme**

© Henrietta Marrie and Adrian Marrie 2014

Appendix 2

Matrix for HHS audits based on Queensland Health's policy and administrative settings: Reworked version based on discussions at ADCQ Workshop, 12 November 2018

Key Indicators and Criteria	Scoring
1. Participation in HHS governance	
• **Good governance**	**Total out of 10**
- Board interaction with Aboriginal and Torres Strait Islander community	3
- HHS Aboriginal and Torres Strait Islander health performance reviewed by Board at least 2x/year	4
- Direct input to board by HHS Aboriginal and Torres Strait Islander Community Consultative Committee	3
• **Aboriginal and Torres Strait Islander representation at board level**	**Total out of 10**
• **Inclusion in Executive Management Structure**	**Total out of 10**
- Aboriginal and Torres Strait Islander Health Division	5
- Aboriginal/Torres Strait Islander Executive Director	5
Total	**30**
2. Policy implementation	
• **Improving Aboriginal and Torres Strait Islander Health Outcomes**	**Total out of 10**
- Explicitly identified as a strategic priority in HHS Strategic Plan	5
- Aboriginal and Torres Strait Islander health outcome KPIs explicitly referred to in HHS Strategic Plan	5
• **Community engagement**	**Total out of 10**
- Aboriginal and Torres Strait Islander community consultative body	3
- Aboriginal and Torres Strait Islander community engagement strategy	3
- HHS Aboriginal and Torres Strait Islander community newsletter/e-letter	2
- At least one Aboriginal and Torres Strait Islander community forum/meeting per year convened by the HHS chief executive	2
• **Public Reporting and Accountability (via annual report)**	**Total out of 10**
- Traditional Owner acknowledgement	1
- Improving Aboriginal and Torres Strait Islander health outcomes	
(i) Separate section in report devoted to Aboriginal and Torres Strait Islander health	1
(ii) Reporting on KPIs contained in current health service agreement	1
- Policy references	
(i) Cultural Capability Framework	1
(ii) Making Tracks	1
- Aboriginal and Torres Strait Islander health division/unit placement on HHS organisational structure/chart	1
- Data on Aboriginal and Torres Strait Islander access to and delivery of services	1
- Aboriginal and Torres Strait Islander Employment	
(v) Data on Aboriginal and Torres Strait Islander employment	1
(ii) Reference to workforce planning, recruitment, etc.	1
- Other recognition (e.g., awards, scholarships, etc.)	1
Total	**30**
3. Service delivery and Partnerships	
• **Aboriginal and Torres Strait Islander HHS Plan**	**Total out of 10**
- Co-designed with ATSICCHO(s) in HHS region	2
- Formal agreement with ATSICCHO(s) in HHS region (e.g., MoU)	2

- Commitment to Continuous Quality Improvement	2
- Mutually agreed KPIs	2
- Clear statement of parties’ responsibilities (eg, sharing of patient health records)	2
• **Cultural safety**	**Total out of 10**
- Cultural safety policy/strategy	4
- Capacity to deliver Cultural Safety Training (CST)	3
- Proportion of staff trained	3
• **Selected Health Service Performance Indicators**	**Total out of 10**
- Estimated level of completion of Indigenous status – specifically the reporting of ‘not stated’ on admission	2
- Discharges against medical advice (DAMA)	2
- Potentially preventable hospitalisations (PPH)	2
- Access to mental health services	2
- Low birth-weight babies	2
Total	**30**

4. Recruitment and employment

• **Aboriginal and Torres Strait Islander health workforce development**	**Total out of 20**
- Aboriginal and Torres Strait Islander workforce development policy/strategy/framework (to also include identified positions according to their nature, role, consumer type and objectives of the service to be provided)	4
- HHS KPI for Aboriginal and Torres Strait Islander employment	4
- Number of Aboriginal and Torres Strait Islander health practitioners, health Workers and liaison officers	4
- Number of identified Aboriginal and Torres Strait Islander positions	4
- Number of salary bands occupied by Aboriginal and Torres Strait Islander employees	4
• **Aboriginal and Torres Strait Islander participation in the health workforce**	**Total out of 10**
- Managerial and clerical	1.5
- Medical including Visiting Medical Officers (VMOs)	2
- Nurses	2
- Operational and Support Services	1.5
- Trade and Artisans	1.5
- Health Practitioners (Professional and Technical)	1.5
Total	**30**

5.Financial Accountability and Reporting: Closing the Gap Funding

• **Commonwealth contribution to HHS**	**Total out of 10**
• **Queensland contribution to Indigenous specific health services and programs**	**Total out of 10**
- Making Tracks funded services (as per HHS Service Agreement)	5
- Indigenous-specific non-Making Tracks health services (as per HHS Service Agreement)	5
Total	**20**

Score	**140**

Institutional Rating scored against criteria

Score:	**>110**	**80-109**	**60-79**	**40-59**	**20-39**	**<20**
Evidence of Inst. Racism:	**Very Low**	**Low**	**Moderate**	**High**	**Very High**	**Extreme**

Matrix history

THE MATRIX FOR IDENTIFYING, MEASURING AND MONITORING INSTITUTIONAL RACISM WITHIN PUBLIC HOSPITALS AND HEALTH SERVICES – A BRIEF HISTORY

In November 2013 Henrietta Marrie (Bukal Consultancy Services P/L) was contracted by the CE of the Cairns and Hinterland Hospital and Health Services (CHHHS) to carry out an investigation into alleged racist behaviours by non-Indigenous staff against Aboriginal and Torres Strait Islander employees. At the time the CHHHS provided hospital and other healthcare services to about 40,000 Aboriginal and Torres Strait Islander people in the Cairns, Cape York and Torres Strait regions – a population roughly equal to the Aboriginal population of SA. This population constituted about 15% of the overall population for the total area, with a recognised excess burden of disease and rate of hospitalisation more than four times the Queensland average. Anecdotally, Aboriginal and Torres Strait Islander people constituted between a quarter and a third of the Cairns Hospital's patients. However, due to recent government staff cut-backs, the number of Aboriginal and Torres Strait Islander people in the CHHHS workforce fell from 4.25% of the total workforce in June 2010 to 2.97% by December 2013. In July 2013 the stand-alone Division of Aboriginal and Torres Strait Islander Health was amalgamated with another division to create a "super" division, and the Aboriginal executive director made redundant. There was also no Aboriginal and Torres Strait Islander representation on the CHHHS board. During interviews it became very apparent that Aboriginal and Torres Strait Islander staff felt very marginalised and disempowered.

The confidential report was delivered to the CE in February 2014. During the investigation in which many interviews were conducted with both Indigenous and non-Indigenous employees in the different employment streams. Indigenous health policy research and comparative analysis of neighbouring Hospital and Health Services (HHSs) was undertaken to gain a better understanding of HHS culture. It became apparent that many key elements of both federal and Queensland Health (QH) policies designed to close the gap in health disparities between Indigenous and non-Indigenous Australians were not being implemented at the HHS level. It also quickly became apparent that, in addition to evidence of personal and casual racism against Indigenous staff and patients, there was also overwhelming evidence of institutional racism. This was found in the documents routinely published by the CHHHS – annual reports; health service agreements; board meeting summaries; operational, strategic and community engagement plans, etc., in which federal and Queensland Close the Gap policy directives were being ignored.

While the authors of the Matrix had undertaken post-graduate studies in race relations some decades earlier, the situation that emerged had all the classic symptoms of institutional racism as articulated by Carmichael and Hamilton in their book Black Power (1967). Believing that there might be a tool already in existence that could be readily used to externally analyse the extent of institutional racism in the CHHHS, the authors conducted a comprehensive internet search, but could find nothing that suited their purpose, save an institutional racism tool-kit created by the Seattle Human Services Coalition (SHSC) in 2005. Based on their own understanding of institutional racism from their studies and the structure provided by the SHSC Tool-kit, the authors, despite not having any public health background, set about creating their own tool for measuring institutional racism based on a simple measuring system and only using publicly available information to both construct their Matrix and to do the scoring. The idea was to begin by creating a template that then could be adapted for each state and territory's health legislation and policy settings [Appendix 1], create the setting for Queensland and then test the Matrix on the CHHHS as a case study which was carried out in June 2014. This research and development was done as an unfunded, private initiative without any consultation with the wider Indigenous and non-Indigenous communities

around Cairns. The construction of the Matrix, the choice of the five key indicators, and the selection of the criteria to be measured, therefore reflect the personal but informed choices of the authors.

The resulting document appeared under two different titles: (i) The Cairns and Hinterland Hospital and Health Service: A Case Study in Institutional Racism (Marrie A 2014) which was sent to the ADCQ and AHRC Commissioners; and (ii) A Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services (Marrie and Marrie 2014) which was distributed more widely. The CHHHS Matrix audit delivered a score of 14/140 points placing the CHHHS at the extreme level of institutional racism. The case study was not published but copies were sent to the Australian Human Rights Commission, the Aboriginal and Torres Strait Islander Social Justice Commissioner, the Close the Gap Campaign Steering Committee Secretariat, some Indigenous health academics and institutions, and the Australian Institute of Health and Welfare. Opportunities were also taken to meet with representatives of organisations such as the Australian Healthcare and Hospitals Association (AHHA) and the Lowitja Institute when they visited Cairns. On its completion, the case study was also given to the regional manager of the far north Queensland office of the Anti-Discrimination Commission Queensland (ADCQ).

With the approval of the ADCQ Commissioner, the regional manager established the Optimal Health Project Team comprising the Matrix authors, executives of the four local ATSICCHOs, a CHHHS executive and senior Indigenous health academics. The Project Team met bi-monthly over the next 2 years and discussed ways in which the findings of the case study could be addressed. The Commissioner also had the case study and its methodology reviewed by a local public health academic, Robyn McDermott (Professor of Public Health Medicine, Centre for Chronic Disease Prevention, James Cook University), in September 2015. Following a very favourable review, and with funding provided by the Queensland Aboriginal and Islander Health Council (QAIHC), the Commissioner contracted one of the Matrix authors to undertake a Matrix audit of all of Queensland's 16 HHSs. The Matrix was given a preliminary trial in the early months of 2016 to see how it would cope with the enormous diversity of the HHSs, and with some tweaking, the audit officially began in October 2016 and was completed when the report Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services (Marrie, A 2017) was delivered to the Commissioner in early March 2017.

The findings were particularly disturbing. Ten of the 16 HHSs rated at the extreme level of Institutional racism, while the other six rated very high. However, the Commissioner wished to focus on the potential of the report to provide a framework for discussion – as implied in the report's title - through which the various findings of the report could be addressed. He was particularly concerned to keep the findings of the report away from the media so that QH and the HHSs could have time to consider the report without being drawn into reacting to it. Consequently, the report was embargoed. A meeting was held with the D-G and senior staff of QH in August 2017, following which QH crafted its own response to the report. The response, the Statement of Action towards Closing the Gap in health outcomes, was released in December 2017 committing HHS boards and executives to the following three actions:

- Action 1: Promote opportunities to embed Aboriginal and Torres Strait Islander representation in Queensland Health leadership, governance and workforce.
- Action 2: Improve local engagement and partnerships between Queensland Health and Aboriginal and Torres Strait Islander people, communities and organisations.
- Action 3: Improve transparency, reporting and accountability in Closing the Gap progress.

For each action, another four action possibilities were included to produce an overall outcome in which an "Enhanced Queensland Health cultural capability will reduce discrimination based on race and increase access to culturally safe and responsive health care services to Aboriginal and Torres Strait Islander people." [see below for the link to the Statement of Action]

During the first half of 2018, all the HHS boards and executives were each given the opportunity to digest the Matrix audit of their own HHS. Issues about the Matrix were aired and in November 2018, ADCQ

convened a workshop to review the Matrix and amend it to better reflect the circumstances of Queensland's HHSs for the purposes of future audits in keeping with the monitoring function of the Matrix. The 12 workshop members included senior representatives from QH's Aboriginal and Torres Strait Islander Health Branch, HHS board members and CEs, AHHA, QAIHC and ATSICCHO representatives, ADCQ's Commissioner and Deputy, and the Matrix authors. Several changes were made to the Matrix used in the original 2017 audit [see Appendix 2].

It is anticipated that by following through with these actions Queensland's HHSs could improve their Matrix scores by 40-50 points, thereby reducing their institutional racism rating from the extreme to very-high levels found in the ADCQ 2017 report to medium to low levels by the time the next Matrix audit is carried out late in 2020. Already noticeable changes have occurred with representation of Aboriginal and Torres Strait Islander people on HHS boards increasing from 9 positions in 2017 to 17 as at June 2019. There are also four new identified executive directors of Aboriginal and Torres Strait Islander health among the HHSs and other Aboriginal and Torres Strait Islander people have been appointed to other senior positions across QH (QHRC[32] Deputy Commissioner Neroli Holmes and Kathy Brown, Senior Director QH pers. com. 19 August 2019). With effectively another year to go before the next audit, further changes could be expected.

The two most important aspects concerning the ADCQ 2017 report are:

- The focus by the ADCQ Commissioner on using the report as a framework for discussion about institutional racism and how it could be reduced through targeted interventions across Queensland's 16 HSSs.
- The "buy-in" to the report by QH, thereby setting a valuable precedent by a government in addressing institutional racism.

The embargo was lifted on the report after 22 months and, accompanied by a media statement, the report was released on 4 December 2018.

The key documents associated with the ADCQ report, including the report itself, can be found at: www.qhrc.qld.gov.au/resources/reports/health-equity These documents are:

- 2017 Health equity report (MS Word Document, 948.7 KB) : Addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland's public hospital and health services, by Adrian Marrie (Bukal Consultancy Services Pty Ltd)
- 2018 Health equity report addendum by Adrian Marrie (MS Word Document, 14.2 KB) .
- Communique: Panel of Aboriginal and Torres Strait Islander health experts (MS Word Document, 87.9 KB) (12 November 2018)
- Queensland Health response: Addressing institutional barriers to health equity (PDF File, 381.8 KB)(26 November 2018)

Commission Health Equity report media release: Audit finds high levels of institutional racism in Queensland's health system, but experts hopeful of a brighter future.

[32] On 1/7/2019 the ADCQ was replaced by the Queensland Human Rights Commission

Glossary

ADCQ	Anti-Discrimination Commission Queensland (now the Queensland Human Rights Commission)
AHHA	Australian Healthcare and Hospitals Association
AHRC	Australian Human Rights Commission
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
ATSIHPFPM	Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures (AHMAC, 2011)
ATSISJC	Aboriginal and Torres Strait Islander Social Justice Commissioner
CHHHS	Cairns and Hinterland Hospital and Health Service
COAG	Council of Australian Governments
DAMA	Discharge against Medical Advice
HHS	Hospital and Health Service (the terminology used in Queensland
HPCSA	Health Performance Council South Australia
LHN	Local Health Network
NHRA	*National Health Reform Agreement* (COAG 2011)
NIRA	*National Indigenous Reform Agreement (Closing the Gap)* (COAG 2008)
NPACGIHO	*National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: National Healthcare Agreement* (COAG 2009)
PPHA	Potentially Preventable Hospital Admissions
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
SHSC	Seattle Human Services Coalition

References

Australian Health Ministers' Advisory Council (AHMAC), 2011. Aboriginal and Torres Strait Islander Health Performance Framework (HPF) Performance Measures (Figure 1). Canberra

Department of Health and Ageing, 2013a. SA Health Aboriginal Culture and History Handbook. Adelaide.

Department of Health and Ageing, 2013b. SA Health Guide for Engaging with Aboriginal People. Adelaide;

Marrie, A. 2017. Addressing Institutional Barriers to Health Equity for Aboriginal and Torres Strait Islander People in Queensland's Public Hospital and Health Services. Report to Commissioner Kevin Cocks AM. Anti-Discrimination Commission Queensland (now the Queensland Human Rights Commission), Brisbane.

SA Health, 2019. Aboriginal Health Care Framework 2019-2024. SA Health, Adelaide. [under development]

SA Health, 2018. Consumer and Community Engagement Governance Model – consumer and community advisory groups. SA Health Adelaide.

SA Health, 2017a. SA Health Aboriginal Cultural Learning Framework. Department of Health and Ageing, Adelaide.

SA Health, 2017b. SA Health Aboriginal Workforce Framework 2017-2022. SA Health, Adelaide.

SA Health, 2017c. SA Health Strategic Plan 2017 to 2020. SA Health, Adelaide.

SA Health, 2017d. SA Health Strategic Plan 2017 to 2020: Early Actions. SA Health, Adelaide.

SA Health, 2015. Policy Guideline: Consumer and Community Advisory Committee/ Group (CACAC/CAG) Policy Guideline and Toolkit. SA Health, Adelaide.

SA Health, 2014. Reconciliation Framework for Action 2014-2019. SA Health, Adelaide.

SA Health, 2010. Aboriginal Health Care Plan 2010-2016. SA Health, Adelaide.

Seattle Human Services Coalition, 2005. Identifying Institutional Racism Folio: Tools to assist human service organizations identify and eliminate institutional racism in their organization (SHSC IDIR Folio). SHSC, Seattle. shsc@shscoalition.org