

THE QUALITY OF INDIGENOUS IDENTIFICATION AND OTHER DEMOGRAPHIC DATA IN AUSTRALIAN HOSPITAL MORBIDITY RECORDS

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ABSTRACT

Accurate recording of patient Indigenous status in hospital separations data is critical to analyses of health service use by Aboriginal and Torres Strait Islander Australians, who have relatively poor health. The accuracy of these data is, however, not well understood. In 1998, a methodology for assessing the data accuracy was piloted in 11 public hospitals. Data were collected for 8,267 patients using a personal interview, and compared with the corresponding routinely collected data. Among the 11 hospitals, the proportion of patients correctly recorded as Indigenous ranged from 55% to 100%. Overall, hospitals with high proportions of Indigenous persons in their catchment areas reported more accurate data. The methodology has since been used to assess data quality in hospitals in two Australian States and to promote best practice data collection.

KEY WORDS: Indigenous status, hospital morbidity data, Australia

1. INTRODUCTION

1.1 Background

Australia's Aboriginal and Torres Strait Islander peoples experience much poorer health than the general Australian population (AIHW 2000). Life expectancy at birth for Indigenous Australians in the period 1991-96 was estimated to be 56.9 years for males and 61.7 years for females, considerably lower than the all-Australian estimates of 75.2 years for males and 81.1 years for females. In 1995-97, the age-standardised death rate among Indigenous residents of Western Australia, South Australia and the Northern Territory (for which identification of Indigenous persons in deaths registrations is considered to be of acceptable quality) was about three times the rate for the total Australian population. Although identification of Indigenous persons within hospital morbidity data is considered to be of acceptable quality only in South Australia and the Northern Territory, for Australia overall, there were more than twice as many hospitalisations per 100,000 population (age standardised) for Indigenous persons as for the total population in 1999-00 (AIHW 2001).

Because of the incomplete identification of Aboriginal and Torres Strait Islander peoples in hospital records, death registrations and other administrative data collections, and uncertainties in estimating the size and composition of the Indigenous population, there is uncertainty about the precise magnitude of the health disadvantage of Australia's Indigenous persons and about their use of health services. Recognising this, Australia's *Aboriginal and Torres Strait Islander Health Information Plan.....this time let's make it happen* (ATSIHWIU 1997), made 42 recommendations for the collection and maintenance of quality statistics on the health status of Australia's Indigenous persons, including several relating to hospital separations. The recommendations included that:

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- ‘all jurisdictions pilot a scheme for assessing the completeness of identification in hospital collections by December 1998 and that all jurisdictions should have undertaken sufficient assessment work to derive an estimate of completeness of hospital separations data sets for the States by December 1999’
- ‘quality assessment work be undertaken on all collections on the premise that datasets which have not had the completeness of their Indigenous identification validated are unreliable as sources of statistics’.

To assist jurisdictions to meet these recommendations, the Australian Health Ministers’ Advisory Council (AHMAC) provided funding to develop, pilot and evaluate a methodology for assessing the completeness of Indigenous identification in hospital separation data. The project was approved by the Australian Institute of Health and Welfare (AIHW) Health Ethics Committee, and managed and co-ordinated by the Aboriginal and Torres Strait Islander Health and Welfare Information Unit (ATSIHWIU), a joint program of the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (ABS).

The accurate recording of a patient’s Aboriginal and Torres Strait Islander status and other demographic information in hospital separation records is essential to enable the optimal use of these data for a range of purposes. The National Hospital Morbidity Database at the AIHW, for example, includes records of essentially all hospital separations in Australia, and is used to monitor the use of hospitals by Indigenous people and (as far as separations data will allow) their health status, and for making comparisons with non-Indigenous people.

This paper includes a report of the pilot project, and follow-up information on the recent use of the methodology in hospitals in two Australian States.

1.2 Pilot project objectives

The project encompassed examination of both Aboriginal and Torres Strait Islander status and other demographic data to:

- enable comparison of the accuracy of the Aboriginal and Torres Strait Islander status data with the accuracy of other data
- enable some investigation of how other demographic factors may influence the accuracy of the identification of Aboriginal and Torres Strait Islander persons
- ensure that the procedures developed had broad applicability to enhance future prospects of their implementation in routine data quality control activities.

The primary objectives of the project were to:

- produce a methodology of assessing accuracy of recording Aboriginal and Torres Strait Islander status and other basic demographic information in hospital separations data
- document the procedures involved to enable implementation by hospitals and/or health departments to assess the completeness of recording Aboriginal and Torres Strait Islander status.

The secondary objectives were to:

- provide indicative information about the accuracy of recording Aboriginal and Torres Strait Islander status in hospital separations data and describe some of the factors that influence it
- provide indicative information about accuracy of other demographic data such as sex, date of birth, country of birth and place of usual residence information
- gather data for further analysis of determinants of the completeness of Aboriginal and Torres Strait Islander status.

2. METHODOLOGY

2.1 Data collection at interview

The methodology for assessing the accuracy of the data was to compare the information in the hospital patient records against information obtained in a personal interview with the patient. This method, which had been employed in some previous studies (for example, Condon et al 1998), is based on the assumption that the information collected in the person-to-person interview is correct. The interview is regarded as the 'gold standard' in most circumstances, however, there are some possible exceptions (ATSIHWIU 1999). For example, it was suggested that the Aboriginal and/or Torres Strait Islander status of the interviewer could influence the accuracy of the interview data, so some of the interviews in four of the hospitals in the study were conducted by Aboriginal and/or Torres Strait Islander interviewers.

For the pilot project, 12 hospitals in five of the eight Australian States and Territories were selected to provide a mixture of characteristics including size, geographical location and the proportion of Aboriginal and Torres Strait Islander people living in the hospital's catchment area. Resource limitations and logistical considerations also influenced hospital selection, and precluded the possibility of including hospitals from all jurisdictions. The twelve selected hospitals were located in Victoria (one hospital), South Australia (five hospitals), Queensland (one hospital), the Australian Capital Territory (two hospitals) and the Northern Territory (three hospitals). Hospitals were provided with financial assistance for the project to conduct the patient interviews.

Calculation of the number of interviews required for each hospital was based on the formula $z = 1/(y*y(1-s)s*p)$, depending on:

- the proportion of Aboriginal and/or Torres Strait Islander people that were currently correctly identified in the hospital records (s),
- the proportion of the hospital's patients who actually were Aboriginal and/or Torres Strait Islander people (p), and
- the standard error required for the calculated proportion of Aboriginal and/or Torres Strait Islander people correctly recorded in hospital records (y):

The proportion of patients who were correctly identified, and the proportion who were actually Aboriginal and/or Torres Strait Islander people were estimated, for example from information from previous studies and from information on the population in the hospital's catchment area. The relative standard error was set at about 25%, meaning that there would be a 2 out of 3 chance that the result produced would be accurate to within 25%. Sample sizes would have been unpractically high if a much greater degree of accuracy was required. Some modifications were made to the sample sizes for practical considerations (such as time required to complete interviews), but this was in keeping with the primary objective of the study, which was to develop and document appropriate procedures. Calculated sample sizes for the hospitals that participated ranged from 100 to 1500 patients.

All hospital patients who had been admitted and were in hospital on the day interviewers visited the hospital were considered eligible for interview. Consent was obtained from each patient prior to the interviews being conducted; two hospitals required this consent to be in writing. Children and teenagers were considered eligible provided that parental or guardian consent was obtained. However, excluded from interviews were patients in intensive care units and others considered by ward staff to be not well enough or not competent enough to participate.

Patients were otherwise selected to provide a complete and representative sample of patients in the hospital. Same day and longer stay patients were to be included in similar proportions to the hospital's overall activity, and all wards and parts of the hospital were to be covered. In practice, this meant interviewers going to all wards and seeking to contact all eligible patients. If a patient had multiple admissions during the interview period, they may have been interviewed more than once, but this was not considered to have a major impact on the development of the methodology.

In most cases the project was co-ordinated within the hospital by staff from medical records units. Interviews were conducted by hospital staff, including Aboriginal hospital liaison officers, nurses, medical records staff and ward clerks, or by people recruited from outside the hospitals. Interviewers received training in the purposes of the study and how to conduct the interviews.

Interviewers collected data on six characteristics of each patient. These were:

- hospital record number
- sex
- Aboriginal and/or Torres Strait Islander status
- country of birth
- date of birth, and
- place of residence

Patients were asked the ABS standard question to determine Aboriginal and/or Torres Strait Islander status:

Are you of Aboriginal or Torres Strait Islander origin?	
<i>For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.</i>	
<input type="checkbox"/>	No
<input type="checkbox"/>	Yes, Aboriginal
<input type="checkbox"/>	Yes, Torres Strait Islander

This is also the question set out in Australia's *National Health Data Dictionary* for use in the collection of hospital morbidity data throughout Australia. Responses to this question asked at the Census also form the basis of ABS estimates of the Aboriginal and Torres Strait Islander population.

2.2 Data matching and analysis

Data from the person to person interview were matched with the existing hospital record, either manually or electronically, using the hospital record numbers. Analysis was conducted within each hospital or by the hospitals in association with the relevant State or Territory health department. Aggregated results from each hospital were provided to the ABS for validation work and completion of the initial analysis.

The interview data and the hospital record (both deidentified) were then to be sent in unit record form to the AIHW to enable additional analysis of possible effects of other patient characteristics on the accuracy of the routinely recorded Aboriginal and/or Torres Strait Islander status and other demographic data. The hospital morbidity data supplied included data usually supplied to the National Hospital Morbidity Database, such as diagnoses, procedures, Australian Refined Diagnosis Related Groups (AR-DRGs) and length of stay.

Linked or linkable data were provided by six hospitals. Three hospitals provided only the interview data, one hospital could only provide the morbidity data, and no data were able to be provided for the other hospital (Hargreaves et al 1999). This was due to some problems with this part of the project including that:

- the request for data for the additional analysis was made separately from the initial face to face discussions to set up the project. This has led to poor understanding of what was requested of the hospitals.
- some hospitals did not seem to have appropriate expertise and/or computing resources to be able to satisfy ad hoc requests for data such as this.
- the original analysis of the ABS data was collated manually by some hospitals and as such electronic records were not available to be provided for the additional analysis.
- the hospitals had insufficient resources or competing priorities that interfered with accommodating such a request (eg routine morbidity data supply).

The linked data were analysed to see if variables in the morbidity data seemed to have any influence on the quality of the demographic data. The accuracy of Aboriginal and/or Torres Strait Islander status data was compared between same day stays and non-same day stays; between medical AR-DRGs, surgical AR-DRGs and other AR-DRGs, and for high and low cost weight AR-DRGs. Same day stays are defined as hospitalisations for which the admission date and the separation date are the same.

3. RESULTS

3.1 Initial analysis

Hospitals were not selected for inclusion in this study in order to produce either national or jurisdictional wide estimates of data accuracy. The results therefore could not be used to estimate correction factors for Aboriginal and/or Torres Strait Islander status in all Australian hospital data.

Eleven of the 12 hospitals that were to participate in the study successfully implemented the procedures outlined. The twelfth hospital did not proceed with the exercise because of its low patient turnover and the time it would have taken to undertake a suitable number of interviews. The elapsed time taken to complete the interviews ranged from 5 to 19 weeks, with the time taken dependent on factors such as patient turnover, availability and suitability.

Table 1: Number of persons interviewed and accuracy of the data in hospital records, for Aboriginal and/or Torres Strait Islander status and other demographic data, by hospital

Hospital	Sample size	Indigenous people in interview	Indigenous people correctly recorded ^(a)	Non-Indigenous people in interview	Non-Indigenous people correctly recorded ^(a)	Records in which sex was correctly recorded	Records in which whether born in Australia was correctly recorded	Records in which date of birth was correctly recorded ^(b)	Records in which place of usual residence was correctly recorded ^(c)
	Number	Number	%	Number	%	%	%	%	%
1	1,518	33	54.5	1,485	97.1	98.9	94.3	95.2	82.5
2	1,390	71	62.0	1,319	99.5	99.9	99.2	99.1	93.7
3	1,462	44	84.1	1,418	100.0	99.9	92.5	98.6	94.4
4	924	13	100.0	911	97.7	100.0	98.5	97.0	97.9
5	290	103	92.2	186	99.5	99.0	98.6	94.1	89.0
6	355	136	91.9	218	94.0	97.5	97.8	91.0	59.2
7	250	167	99.4	83	100.0	100.0	99.6	82.4	87.6
8	609	38	55.3	570	96.8	99.8	95.7	95.1	94.8
9	395	4	100.0	391	98.2	98.5	100.0	100.0	100.0
10	1019	20	55.0	999	100.0	99.1	96.6	94.1	89.7
11	56	19	78.9	37	100.0	96.4	96.4	83.9	89.3

(a) People with 'Unknown' Aboriginal and/or Torres Strait Islander status were included in the counts of those interviewed, but not in the counts of those for whom Aboriginal and/or Torres Strait Islander status was recorded correctly in the hospital records.

(b) The inclusion of records which had an estimated date of birth varied.

(c) The level at which matching was undertaken varied by jurisdiction; postcode, Statistical Local Area, community and suburb were used.

The number of refusals was generally low, although in one hospital, there were 342 refusals for 1,518 interviews, felt to be partially explained by the requirement for patients to consent in writing at that hospital.

The data collected by the 11 hospitals provided sufficient information in the initial analysis to enable them to make an assessment of the accuracy of recording patients' Indigenous status and the other demographic information. Results indicate that the number of Aboriginal and/or Torres Strait Islander people recorded in hospital separation data was an underestimate of the number of Aboriginal and/or Torres Strait Islander people who were admitted patients. The degree of completeness of the recording of Aboriginal and/or Torres Strait Islander status for Indigenous people varied widely from hospital to hospital, ranging from approximately 55% to 100% (Table 1).

For non-Indigenous people, the degree of accuracy of recording of Aboriginal and/or Torres Strait Islander status was consistently higher than for Aboriginal and/or Torres Strait Islander people, ranging from 94% to 100%. The recording of age, sex, country of birth and place of usual residence also showed higher levels of accuracy than the recording of Aboriginal and/or Torres Strait Islander status for Indigenous people.

Results for hospitals were amalgamated and grouped according to the proportion of Aboriginal and/or Torres Strait Islander people living in their catchment areas. The accurate recording of Indigenous status appeared to be higher in hospitals in which a higher proportion of Aboriginal and/or Torres Strait Islander people lived in the catchment area and was similar to the accuracy of recording for non-Indigenous people (Table 2). Non-Indigenous people were found to be correctly recorded most of the time. It should be noted that this apparent trend between catchment areas and higher and lower proportions of Aboriginal and/or Torres Strait Islander persons does not mean that all hospitals are likely to record Aboriginal and/or Torres Strait Islander status based on this trend.

The correct recording of the Aboriginal and/or Torres Strait Islander status was more common in hospitals outside the capital cities (Table 3). The accuracy of recording of Aboriginal and/or Torres Strait Islander status for non-Indigenous people did not vary much between these groups of hospitals. The accuracy of recording was also compared between large and small hospitals, and differences were almost identical to those between capital city and other areas.

For hospitals with a low proportion of Aboriginal and/or Torres Strait Islander people in their catchment areas (for which there were sufficient data), the Aboriginal and/or Torres Strait Islander status of the

Table 2: Number of persons interviewed and accuracy of Aboriginal and/or Torres Strait Islander status data, by proportion of people in the catchment area who were Aboriginal and/or Torres Strait Islander Australians

	Indigenous people in interview	Indigenous people correctly recorded	Non-Indigenous people in interview	Non-Indigenous people correctly recorded
	Number	%	Number	%
High proportion ($\geq 15\%$) of Aboriginal and/or Torres Strait Islander people living in the catchment area ^(a)	425	94.4	524	97.3
Low proportion ($< 15\%$) of Aboriginal and/or Torres Strait Islander people living in the catchment area ^(b)	223	66.4	7,093	98.6

(a) Hospitals 5, 6, 7, 11. The proportion of Aboriginal and/or Torres Strait Islander people in the catchment areas for these hospitals was about 15% or more.

(b) Hospitals 1, 2, 3, 4, 8, 9, 10.

Table 3: Number of persons interviewed and accuracy of Aboriginal and/or Torres Strait Islander status data, by location of hospital

	Indigenous people in interview	Indigenous people correctly recorded	Non-Indigenous people in interview	Non-Indigenous people correctly recorded
	Number	%	Number	%
Hospitals in capital cities ^(a)	321	78.5	6,741	98.7
Hospitals in other areas ^(b)	327	90.8	876	97.8

(a) Hospitals 1, 2, 3, 4, 6, 9, 10.

(b) Hospitals 5, 7, 8, 11.

interviewer did not seem to influence how Aboriginal and/or Torres Strait Islander patients identified at interview, compared with how they were identified in the routinely collected data.

Further results and discussion of this initial analysis can be found in the report of the pilot project (ATSIHWIU 1999).

3.2 Additional analysis using linked interview and hospital morbidity data

As noted above, linked or linkable data were provided by six hospitals, relating to a total of 6,915 patients. The linked data were analysed to determine whether variables in the morbidity data seemed to have any influence on the quality of the Aboriginal and/or Torres Strait Islander status data and other demographic data. As for the interview data, these results should only be regarded as indicative, or as examples of the types of analyses that can be undertaken with such linked data to, for example, calculate different correction factors for different groups of patients.

Table 4 shows that the accuracy of the data on Aboriginal and/or Torres Strait Islander status did not vary markedly with length of stay (same day or other). The accuracy also did not vary with the type of AR-DRG (surgical, medical or other), or with the relative cost weight (resource intensity) of the AR-DRG.

Table 5 similarly shows that the accuracy of the data on place of birth (Australia or elsewhere) did not markedly vary with length of stay, broad AR-DRG grouping, or AR-DRG cost weight group.

Table 4: Number of persons interviewed and accuracy of Aboriginal and/or Torres Strait Islander status data, by same day status and AR-DRG category

	Indigenous people in interview	Indigenous people correctly recorded	Non-Indigenous people in interview	Non-Indigenous people correctly recorded
	Number	%	Number	%
Same day stay	98	87	1,911	99
Non-same day stay	264	81	4,545	99
Medical AR-DRG	266	86	3,670	99
Surgical AR-DRG	67	81	1,843	98
Other AR-DRG	19	58	727	99
AR-DRG cost weight < 1.00	229	81	3,644	99
AR-DRG cost weight ≥ 1.00	123	88	2,596	99

Table 5: Number of persons interviewed and accuracy of data on place of birth, by same day status and AR-DRG category

	Born in Australia in interview	Born in Australia correctly recorded	Born outside Australia in interview	Born outside Australia correctly recorded
	Number	%	Number	%
Same day stay	1,320	98	690	98
Non-same day stay	3,685	98	1,125	96
Medical AR-DRG	2,864	99	1,073	96
Surgical AR-DRG	1,430	97	481	97
Other AR-DRG	491	98	255	96
AR-DRG cost weight < 1.00	2,817	98	1,059	97
AR-DRG cost weight ≥ 1.00	1968	98	750	96

4. CONCLUSIONS OF THE PILOT PROJECT

The pilot project demonstrated that it was possible to assess data quality using a simple set of procedures producing valuable results, although analysis with linked morbidity records may not always be feasible.

The results of the study indicated that the accuracy of recording a person's Aboriginal and/or Torres Strait Islander status varied widely from hospital to hospital. The proportion of Aboriginal and/or Torres Strait Islander people living in the hospital's catchment area seemed to be a major influence on the level of accuracy, with other characteristics of the patient and the hospital stay apparently not influential. More accurate reporting in areas with a high proportion of Aboriginal and/or Torres Strait Islander people may have been attributable to hospitals and staff in these areas being more aware of the importance of accurately recording Aboriginal and/or Torres Strait Islander status, but it may be that Aboriginal and/or Torres Strait Islander people were more 'obvious' in these areas (ATSIHWIU 1999). Other factors influencing higher accuracy in some hospitals appeared to include the employment of Aboriginal Hospital Liaison Officers who routinely contacted all Aboriginal patients in the hospital, for example, and requested corrections for incorrect data that came to their attention. More generally, the 'culture' of the hospital in relation to accurate recording of patient data was also seen as important.

The procedures developed for the pilot were published in full (ATSIHWIU 1999), to enable other hospitals and health departments to use them to assess the quality of Aboriginal and/or Torres Strait Islander identification in the data they have responsibility for. The methodology has since been used to assess data quality in hospitals in two Australian States and to promote best practice data collection.

5. USE OF THE METHODOLOGY FOLLOWING THE PILOT

5.1 Western Australian hospitals, 2000

The pilot project methodology was used by the Health Department of Western Australia between July 2000 and January 2001 (Young 2001). The sample of 26 hospitals was selected, stratified by amalgamated health region, with a random sample taken of all hospitals in each. Interview sample sizes were determined for assessment of the accuracy of data on Aboriginal and/or Torres Strait Islander status for each amalgamated region, and with the sample size for each hospital proportional to its patient throughput. The study was preceded by a two-day pilot in July 2000, in which a stratification within the hospital, based on types of admissions, was assessed. This stratification was, however, found to be difficult and it was decided that interviewers would instead cover all wards deemed appropriate by the hospital.

Data were collected in 10,106 face-to-face interviews conducted by experienced interviewers who were specially recruited and trained for the task. Interviewers were Aboriginal in areas where the majority of patients were Aboriginal and/or Torres Strait Islander, in accordance with ethical guidelines. It was found that the use of printouts of patients who had already been interviewed was the only accurate way to ensure patients had not already been interviewed, as patients did not always recall if they had been interviewed previously. Optimum times for interviewing were found to be between 7.30am and 8.30am for day patients (before they had their surgery) and around lunchtime for other patients. Sample sizes ranged from nine to 1,484 patients and elapsed time for interviews from 4 to 16 weeks. About 1% of patients approached refused to participate.

Overall, 85.5% of Aboriginal and/or Torres Strait Islander patients were found to have been recorded as such in the hospital records, with the level of accuracy varying from 78.3% in the metropolitan health regions to 93.5% in the Kimberley/Pilbara Health Region. In line with the results of the pilot project, the latter area, with the highest data accuracy, also had the highest proportion of Aboriginal and/or Torres Strait Islander people in its catchment area. However, there were higher levels of accuracy than would have been expected (based on catchment populations) in the Great Southern/South West Region. Also in line with the pilot project, the level of accuracy did not vary greatly with patient age or sex or according to whether they were hospitalised in a rural or urban area. About 5% of patients who were readmitted and reinterviewed in the study period identified as Aboriginal and/or Torres Strait Islander in one interview and as non-Indigenous in another; these patients were recorded as Aboriginal and/or Torres Strait Islander in the final data set. The accuracy of recording Aboriginal and/or Torres Strait Islander status for non-Indigenous persons was higher than for Aboriginal and/or Torres Strait Islander patients, at 99.5% overall for the State.

The accuracy of recording sex was relatively high (99.5% overall), as was the accuracy of recording whether a patient was born in Australia (97.2%), and their date of birth (94.9%). The accuracy of information on the patient's place of usual residence was somewhat lower (90.9%), possibly affected by the use of 'approximate' addresses at interview, when patients who had more than one address were unable to recall which one had been given to the admission clerk.

The authors calculated correction factors for the Aboriginal and/or Torres Strait Islander status data to improve the usefulness of the available data collections. They recommended that, in future assessments of data accuracy, the question on sex be located at the end of the questionnaire, and not verbally asked, as it had been found very amusing by patients. They also commented that it is important that time is spent in training to include strategies on how to deal with hostile patients who, for example, interpreted the study to be an example of Aboriginal and Torres Strait Islander peoples receiving better treatment.

5.2 Queensland hospitals, 2000

Queensland Health measured the accuracy of data for admitted patients in two hospitals in February and March 2000 (Mahoney 2001). Hospital records were compared with patient details as reported at interview with trained agency staff. A questionnaire was developed and used to collect data on date of birth, place of birth (Australia or elsewhere), Aboriginal and/or Torres Strait Islander status, transfer status, hospital insurance cover and Department of Veterans' Affairs eligibility, and thus differed from the exact methodology of the pilot project. Data were entered into a database and matched with admission records.

A total of 1,149 interviews were conducted, over two weeks in one hospital and over one week in the other. A further 156 patients had not been well enough to be interviewed. The interviews represented 1,101 patients for which 1,090 records were able to be matched. The analysis of the data showed that the Aboriginal and/or Torres Strait Islander status was generally under-reported in the hospital records. Five of the 22 Aboriginal and/or Torres Strait Islander patients at one hospital were not correctly identified (with one identified as of Torres Strait Islander origin in the interview, but of Aboriginal origin in the hospital records), and three people were recorded as Aboriginal and/or Torres Strait Islander persons in the hospital records, but as non-Indigenous at interview. At the other hospital, five of the 12 Aboriginal and/or Torres Strait Islander patients were not correctly identified, and two persons who were recorded as non-Indigenous at the interview were recorded as Aboriginal and/or Torres Strait Islander persons in the hospital record. Data on place of birth (Australia or elsewhere) was accurate for 98% of patients overall.

The authors of the report noted that the advantages of using this methodology to determine the accuracy of admitted patient data need to be considered in the light of the costs involved in conducting the patient interviews and in data entry and analysis, and suggested that other methods of assessing data accuracy could be investigated in the future. They also noted that in only 5 of the 1,134 interviews, the patient did not give a response to the question on Aboriginal and/or Torres Strait Islander status and, for 22 patients for whom no data on Aboriginal and/or Torres Strait Islander status was available in the hospital record, data were able to be collected at interview. They concluded that this indicated that the personal interview was a good method for collecting these data.

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