Editorial

Governance in health information management

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Welcome to the governance issue of HIM-Interchange. As readers of HIM-I, we are all no doubt familiar with the governance arrangements that influence the particular area of health information management in which we work, those parts of the information lifecycle in which we spend most of our working life. Or are we? For some, governance of health information may be more like the air around us; so ever-present, so integral to our working life that in some ways we do not consciously think about it.

Rather, we naturally work within that environment. I suggest that all health information management professionals respond to, and work within at least one set (but usually more layers) of governance arrangements (organisational, local, state, national), regardless of whether they think about it in those terms or not. Additionally, many of us participate at different levels in the establishment, amendment, implementation and enforcement of the health information governance arrangements. If you are not sure, consider your involvement in the definition, acquisition, access, use, release, and disposal of information, the management of information-related projects, or teaching of health information management courses. All of these roles will be undertaken within the context of some form of governance, ranging in spectrum from highly formal (such as Acts and other legislative instruments) to less formal arrangements such as committee structures, unit policies, procedures and guidelines. To illustrate how acclimatised we are in Australia to the impact of health information governance arrangements, consider the rhetorical question: how many hospitals really questioned whether or not to implement the 8th edition of ICD-10-AM from 1 July 2013?

Minds greater than mine have written about the nature of governance. In simple terms, governance relates to the authorising environment in which decisions are made and activity occurs. A quick literature review or Google search will uncover many papers on data and information governance, health information governance and information governance in e-health. I like the Wikipedia information governance definition:

1 Accessed 10 July
Information governance, or IG, is an emerging term used to encompass the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information at an enterprise level, supporting an organization’s immediate and future regulatory, legal, risk, environmental and operational requirements.

In addition: Regardless of the exact wording, definitions of IG tend to go quite a bit further than traditional records management in order to address all phases of the information life cycle. It incorporates privacy attributes, electronic discovery requirements, storage optimization, and metadata management. In essence, information government is the superset encompassing each of these elements.

While the term (health) information governance may be an emerging term, I suggest it is not an emerging discipline in health, rather an evolving one. For more than fifty years, Health Information Managers (HIMs) (and previously MRAs) have been committed to managing information, albeit in paper and less technologically-advanced forms than are (largely) in use today. I also suggest that in health it is too narrow to consider the scope of information governance to be only within an organisation; rather, many of our information governance arrangements are whole of system based.

With what I hope is now a common understanding of the theme, let’s get back to my analogy! Like air, governance of health information has different qualities in

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**Figure 1: Mud map outlining the various national bodies, governance committees/structures, and instruments relating to health information and e-health in Australia**

*Note: See acronyms list*
different places. The temperature, humidity and wind chill factors are quite different in Tasmania compared to Darwin. Similarly, we have different governance arrangements in different jurisdictions, in the public and private sectors, and in different healthcare settings (such as acute, aged and community care, mental health). Like micro-climate differences, governance arrangements differ among different services despite a lot of commonalities. Services (hospitals, community health services, Medicare Locals and non-government organisations) and other health-related bodies (government health departments, national agencies) should each have their own policies, procedures, and committee structures in place to respond to the larger environment, which includes standards, legislative instruments, agreements and funding arrangements.

Illustrating this point, Nassar et al. (2013), in discussing the electronic health record system in Jordan, highlight the importance of considering governance arrangements wherever you are, and that these must be considered from both a high level (government) perspective through to the local implementation level. The situation in Australia is shown in Figure 1, which presents a mud map of some of the Australian organisations/roles, governance and advisory structures, and instruments that they operate under, at a national level. While this is by no means exhaustive, it illustrates the complex governance environment in which we work in this country.

Similar to the impact of the various factors contributing to climate change, there have for many decades been factors that have resulted in changes in health information governance; however in recent years the changes seem to be more dramatic and be of a much greater magnitude than in previous years. This is where the use of the climate analogy starts to break down. The evolving nature of the governance of health information is not all bad news; it provides challenges and risks, but also I believe, great opportunities for our profession.

In my mind there are three main current issues and trends that are key factors to fast-changing health information governance arrangements within Australia. These are: the impact of national health reform activities; the evolution of technology and use of data in general terms; and the national e-health agenda. Recent issues of HIM-Interchange have included articles about the impact that national health reform will have on HIMs and the broader health sector, both in terms of moving to a national funding model and the skills HIMs can bring to this and related tasks. Less explicit in these articles has been the significant change in national health information governance arrangements, a change due not least to the establishment of a number of new national bodies under the National Health Reform Agreement (NHRA) and National Health Reform Act 2011 (the Act); the Independent Hospital Pricing Authority (IHPA), National Health Performance Authority (NHPA), National Health Funding Body (NHFB)(separate from the Administrator of the National Health Funding Pool (NHFP), ‘the Administrator’), and the Australian Commission on Safety and Quality in Health Care (ACSQHC)(already in existence, but now established as an independent body). In addition there is the creation of the new layer of Medicare Locals, and in a recent paper Peek (2013) described some of the complexities of navigating the health data landscape from the Medicare Local perspective.

Under the NHRA and the Act, the IHPA, NHPA and Administrator all need health data for their various purposes, and are required to develop data plans for consideration by the Standing Council on Health (SCoH), which consists of all Australian Health Ministers. While

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2 Note the theme of HIM-I Volume 2(2)is Health services funding models
some of this information is the same as that historically provided to the AIHW as national minimum datasets (NMDS), there are also new data being requested, some of which has not consistently been captured by states and territories before. This leads to new reporting requirements for health services. Governance issues can be difficult to traverse as each of these national agencies has their own jurisdictional advisory committee, as well as other advisory committees, and participate in the National Health Information and Performance Principal Committee (NHIPPC)3, a principal committee of the Australian Health Ministers Advisory Council (AHMAC) (consisting of the head of each health department, however named), which advises SCoH (notwithstanding that the new national bodies are entitled to report directly to SCoH without AHMAC consideration of issues). Depending on the governance arrangements applicable for a particular topic, for some issues Health Ministers need to all agree on a particular position (such as the performance assessment, reporting and management of Local Hospital Networks outlined in Clause D27 of the NHRA) for it to be considered final and ready to be actioned. Conversely, for other issues the default position is that the document/planned action will go ahead unless all Health Ministers agree to any change, which is the case for the data plans submitted to SCoH. That is, all Health Ministers must agree to provide a direction to change the data plan, or it is considered final. This means one jurisdiction can block changes requested by others.

A positive outcome for HIMs is that the NHRA has brought into greater prominence and referenced (at Clauses B99, 103 and 104), the National Health Information Agreement (NHIA). In this HIM-I issue Gill (2013) discusses the NHIA in the context of the long-standing governance arrangements that underpin national health reporting; detail on how to access the document is provided in my quick links section. The article on governance of health-related classifications in Australia (Hargreaves & Njeru 2013) provides a subject specific example to highlight that many data areas have a long governance history including a number of key stakeholders, which are also adapting to changing environments.

In considering the evolution of technology and use of data, there have been significant changes in health information management areas in the 20 years since I graduated. Jenny Gilder’s reflections (Gilder 2013) provide a charming insight into the very significant changes the profession has witnessed since 1969! Within Health Information Services (or Medical Record Departments) HIMs have been involved in projects to implement electronic tracking systems, scanned medical records and grappled with the need to develop new standards for capturing email addresses and mobile phone numbers in forms and systems, and re-thought storage and retention policies in relation to the new electronic data and telehealth consultations. Outside the HIS area, there has been involvement in the specification and implementation of electronic discharge summaries; new clinical management systems, versions of software and transition to electronic patient administration systems; linkage protocols of disparate data sources; and legislative arrangements relating to health records. All of these things have involved a change in governance arrangements, whether that is confined to changing content and detail of policies and procedures, or changing authorisation environments and stakeholders in part due to changing technology.

Access, use, retention, privacy and security of information are all areas that have evolved significantly over the last few decades. Recently McDonald (2012) outlined changes to the private hospital funding models in Australia over 25 years, which in part highlighted the shift over this time in the increased importance and use of the health information. In the preceding decades the complexity of patient confidentially and privacy arrangements has grown, as highlighted by Wyatt (2013) in the conference report which cites the NSW legislative environment as an example. This is one of the areas in which the governance climate is significantly different depending on who and where you are. Jurisdictional arrangements range from those with significant (overlapping) legislative instruments (including condition specific arrangements, such as for Mental Health or HIV patients) to those with no legislated governance arrangements. The arrangements that apply to you will be dependent on both your location and whether you are a public body or private hospital, as well as other factors. In this edition Burns (2013) provides a timely and significant warning that ignoring such issues in the context of new technology introduces significant personal, professional and financial risks.

Last but not least, let us briefly explore the national e-health environment, utilising the current e-health Memorandum of Understanding (MOU), signed by all Health Ministers earlier in 2013, to provide a rough scope. Again, the governance arrangements can be complex to navigate, in part because some components are funded and governed jointly by all Australian jurisdictions, such as the healthcare identifier (HI) service and clinical terminology activities. Other components, such as the personally-controlled electronic health record (PCEHR) are Commonwealth projects, and therefore although states and territories may be consulted on aspects of the PCEHR development and roll-out, there is no obligation for the jurisdictional advice to be heeded. Similarly, as included in the e-health MOU schedule, the NEHTA work program consists of the ‘Joint funded NEHTA program’ and less explicitly in the MOU that which is not included, such as the work NEHTA is contracted to undertake in relation to the PCEHR on behalf of the Commonwealth.

3 They also participate in a number of the NHIPPC Standing Committees, specifically the National Health Information Standards and Statistics Committee (NHISSC), and the Standing Committee on Performance and Reporting (SCPR)
The priority of developing and incrementally implementing national specifications and standards is recognised within the e-health MOU. The NEHTA Update Report (Bond 2013) in this issue provides an overview not just of NEHTA’s activity in relation to supporting e-health standards, but how their activity relates to that of Standards Australia. I note that HIMs have a significant amount of expertise that they could (and in some instances do) bring to these activities. The importance of creating and implementing standards should not be underestimated if we wish to contribute to developing cohesive systems, particularly in emerging areas. In Australia there are already telehealth systems in place that aren’t interoperable, due precisely to the absence of available standards for implementation when they were being developed.

The new national services and infrastructure require us to carefully consider the assumptions we make, and the possible implications, when considering when and how to adopt them. For example, the Office of the Australian Information Commissioner (OAIC) has a number of roles in relation to the PCEHR and HIS, including investigating complaints about the mishandling of health information in an individual’s PCEHR, and the use of HISs more broadly (outside of the PCEHR), including in public entities. It is important to understand that use of the PCEHR is governed by Commonwealth legislative arrangements, but that when a health service incorporates PCEHR sourced data into systems (in any form including electronic, printed and transcribed), then the local governance arrangements of the data apply (such as those regarding confidentiality, privacy, and retention) and the PCEHR Act is no longer relevant. Considering the impact of uploading information governed by one set of arrangements, which may then be used and downloaded in another will be important for some.

I note we (individually and as a group) have different levels of influence over health information governance arrangements in which we operate. To illustrate by analogy, imagine that I have installed an air conditioner: I can choose when to turn it on so that my house is cool, but I can’t dictate when it will be 40°C in Melbourne. Through my actions in recycling, installing solar panels and fitting appropriate plumbing fixtures I can do my bit to reduce my contribution to climate change (and might not turn on the air conditioner), but my actions won’t stop the inevitable global trends. In the same way, as professionals we can choose to an extent the level at which we want to be engaged in changing health information governance arrangements, in the context that there’ll continue to be the existing ‘change factors’, and almost certainly new issues to contend with. For example, I’m interested to see how the new National Disability Insurance Scheme will affect our work (or not), considering that the majority of those eligible for the scheme have chronic and complex conditions, a target group for using the PCEHR (including, one would hope, access and use as appropriate by carers). By the time this article is in print the federal election result will be known, and either way we could see significant changes to the governance landscape in health.

Lastly, research has shown that global warming is a major cause for an increased rate of extinction of species across the world4. In closing the editorial, I challenge us to consider how we, both individually and as HIMs as a group, are faring in light of our changing professional climate, which encompasses the greater capability and use of technology, national health reform activities and other impacts on our professional environment. I know there are HIMs contributing to governance of health information at many levels, but are there enough? Are we at risk of being concentrated in small pockets, such as coding and casemix? Or worse, are we possibly facing extinction? Are the Health Informaticians the predominant species, or are we working with them, or are we in fact a sub-group of informaticians? Is one of our strengths perceived to be in following and enforcing governance arrangements at a local level (including great secretariat skills in ‘managing’ the governance structure), but not necessarily contributing to setting new directions either locally or more broadly? There are certainly other professional groups that are thriving in the current environment. My hope for HIMs, and HIMAA more broadly, is that we accept the challenges of the current climate and find ways to engage to ensure that we too thrive and take our place as leaders in health information governance arrangements. I have my own personal plan, do you?

References

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