

**Bills Committee on
Electronic Health Record Sharing System Bill**

**The Administration's Response to
Dr Hon Elizabeth QUAT's letter dated 11 July 2014**

This paper sets out the Administration's response to the comments and suggestions raised in Dr Hon Elizabeth QUAT's letter dated 11 July 2014. The Clerk to Bills Committee has provided the Administration with a copy of the letter on 16 July 2014.

Comment / Suggestion No. 1

2. The Administration conducted a two-month public consultation on the "Legal, Privacy and Security Framework for Electronic Health Record Sharing" in December 2011. It was originally proposed in the public consultation document that there should not be any "safe deposit box"¹ in the Electronic Health Record Sharing System (eHRSS). During the consultation, we received 111 responses among which 88 did not comment on this proposal. Among the 23 responses that expressed views on the proposal, 18 were against not providing "safe deposit box" while 5 indicated support or no objection to the original proposal.

3. The Administration reported on the outcome of the public consultation at the meeting of the Panel on Health Services of the Legislative Council on 11 June 2012. In view of the diverse opinions gathered at the meeting and the public consultation, the Administration saw the need to further examine the issue. The Secretary for Food and Health undertook at the meeting that the Administration would conduct a study on providing additional access control over sensitive data with reference to overseas experience. When we reported the progress of the Electronic Health Record (eHR) Programme to the Panel on Health Services on 18 March 2013, we reaffirmed again our undertaking that a study on additional

¹ Paragraph 4.30 of "The Legal, Privacy and Security Framework for Electronic Health Record Sharing Public Consultation Document".

access control for sensitive data would be conducted. In line with the undertaking, we will conduct the study as a priority for the Stage 2 eHR Programme after passage of the eHRSS Bill.

Comment / Suggestion No. 2 to 4

4. The Administration has repeatedly reiterated the diverse views over the “safe deposit box” issue in our previous written and verbal responses. We have reported the views of both the supporting and the objecting parties. The responses of the public consultation conducted in December 2011, as well as the views expressed by the depositions during the meeting of the Bills Committee on 26 May 2014, are also reflecting that no consensus has been reached. The proposed study will provide important background information and analysis on various options to facilitate the decision on the way forward. Pending the outcome of the study, the Administration has no predetermined stance at this stage.

5. We noted the views expressed by the Privacy Commissioner for Personal Data, some patient groups and Members of the Bills Committee. On the other hand, we also heard the reservations expressed by some healthcare professionals and others. All these views will certainly be taken into account. As explained previously, “safe deposit box” is a broad general concept and there is no standard design. We have only limited information on the different overseas practices and experiences based on desktop research. Given the complexity of the issue and the many different overseas approaches, we need to conduct an in-depth study. We understand that similar to Hong Kong, in Europe and Australia the experts and stakeholders also have diverse views and concerns. We will look into the documents mentioned in Dr Hon Elizabeth QUAT’s letter when conducting the study.

6. Australia’s Personally Controlled Electronic Health Record System (PCEHR) was launched in July 2012. It has so far over 1 million consumers (i.e. patients) registered under the system. However, despite the increasing registration, adoption and utilization were only growing slowly and have plateaued. The original design of the PCEHR enabled

consumers to exercise strong control over the content of the health record. After commencement of operation for over a year, it seems that there are “gaps between the expectation of users and what has been delivered” and there are “barriers to increasing usage in clinical settings”. The Australian government accordingly commissioned a review and the report was published in December 2013. The report came up with 38 recommendations. While supporting maintaining the characteristics of high patient control, the review proposed changes such as transition from an “opt-in” model to an “opt-out” model, implementation of a minimum composite requirement to include “demographics”, “current medications and adverse events”, “discharge summaries” and “clinical measurements”, adding a flag to identify the restriction or deletion of document by patients, change of governance structure and conducting educational campaign.

7. The Australian review is a complex subject. In the absence of an in-depth study, it is not possible to fully understand the background and analyse the proposed subtle changes as well as the implications. Moreover, the Australian context is different from Hong Kong’s and the Hong Kong eHRSS is not a replica of the Australian PCEHR.

Comment / Suggestion No. 5

8. There may be different possible arrangements to allow exemption for accessing restricted data in special circumstances overseas. However, there may be different considerations for allowing access to the entire record vis-a-vis access to particular data. In studying the possible forms of system enhancement feature for the next stage of the eHR Programme, the means and circumstances to break relevant access restriction will also be looked into.

Comment / Suggestion No. 6

9. Not all healthcare recipients (HCRs) would automatically become participants of the eHRSS upon receiving healthcare in the Hospital Authority (HA) and/or the Department of Health (DH). Participation in eHRSS is voluntary and requires express and informed joining consent by

HCRs. What Clause 16(1) of the eHRSS Bill stipulates is that when the HCR gives a joining consent to participate in eHRSS, he/she is taken to have given a sharing consent to HA and DH as well.

10. One of the fundamental objectives of eHRSS is fostering public-private collaboration in healthcare delivery. HA and DH, being the healthcare providers (HCPs) of the public sector, have a vast amount of health data. They are valuable for private HCPs and will form the essential building blocks of patients' eHR to enhance the continuity of care of the patients. We have therefore proposed in the public consultation document on "The Legal, Privacy and Security Framework for Electronic Health Record Sharing" published in December 2011 that HCRs' consent to HA and DH shall be part and parcel of their enrolment to eHR sharing. No objection to this proposal was received during the public consultation. We have also briefed the Panel on Health Services on this proposal at its meeting on 12 December 2011. The arrangement would facilitate the registration process and reduce the burden on HCRs, HA and DH.

11. Clause 25 of the Bill includes a *general prohibition* of use of data and information contained in an eHR, while Clause 26 provides that the data and information of a registered HCR may be used for improving the efficiency, quality, continuity or integration of the healthcare provided (or to be provided) to the HCR. These clauses would guard against the use of data and information by any person who has nothing to do with improving the efficiency, quality, continuity or integration of the healthcare provided to the HCR. In addition, through the sharing consent mechanism set out in Clause 12, an HCR has the choice over granting access only to the HCP(s) that has (have) a need to know his/her health data in the eHRSS. The HCR can also revoke the sharing consent given to a particular HCP at any time should he consider that the HCP has no need to access his eHR anymore.

12. Apart from the legislative provisions, the future operation/workflows of the eHRSS are designed to incorporate access control features, similar to many other major computer systems. Authorization of access to the health data in eHR by healthcare

professionals would only be granted to those who have valid registration status contained in the statutory professional registers. Administrative staff in an HCP who has to handle registration or sharing consent of an HCR will only be given access to the HCR's index data (such as name, address, mobile phone number). All accesses to eHR will be logged and traceable. Access of an HCR's eHR will trigger the issue of a notification (such as SMS) to the relevant HCR. If an HCR has doubts upon receiving a notification, the HCR could approach us to file complaints and enquiries.

13. In the public healthcare services setting, the patients often could not foretell which staff would be involved in their treatment processes. The team work approach in the delivery of healthcare would also imply the involvement of other staff outside the consultation room (e.g. pharmacists and medical laboratory technologists). It is not practical to require HCRs to give sharing consent to individual HA or DH staff.

Food and Health Bureau
July 2014