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Report of the Bills Committee on Electronic Health Record Sharing System Bill

Purpose

This paper reports on the deliberations of the Bills Committee on Electronic Health Record Sharing System Bill.

Background

2. Further to a public consultation on the future service delivery model of the healthcare system and the launch of the Public Private Interface - Electronic Patient Record Sharing Pilot Project to test the feasibility and acceptability of electronic health record ("eHR") sharing, the Government proposed to develop eHR sharing as an infrastructure for healthcare reform in the Healthcare Reform Consultation Document entitled "Your Health, Your Life" published in March 2008. Based on the positive response received during the consultation exercise, the Government rolled out a 10-year two-stage Electronic Health Record Programme ("eHR Programme") in 2009 to develop the Electronic Health Record Sharing System ("the System") to provide an infrastructure to enable the sharing of eHRs amongst different healthcare providers ("HCPs") in the public and private sectors with consent of the healthcare recipients ("HCRs"). Apart from developing the sharing infrastructure, a main target of the first stage eHR Programme which spans from 2009-2010 to 2013-2014 is to formulate a legal framework to protect data privacy and system security prior to commissioning the System.

3. At present, the Personal Data (Privacy) Ordinance (Cap. 486) ("the Privacy Ordinance") which sets out the provisions for protection of personal data privacy does not have any specific provision on health-related data other than section 59. General offences against unlawful access to and use of computer and data are

provided for in the Telecommunications Ordinance (Cap. 106) and the Crimes Ordinance (Cap. 200). In view of the unique arrangement of data sharing, the sensitive nature of health records and the need to provide additional safeguards to instil public confidence in the System, the Administration considered it necessary to introduce a new piece of legislation to cater for the new circumstances brought into place by the System.

4. Against this backdrop, the Administration conducted a public consultation exercise on the legal, privacy and security framework ("the framework") for the System in December 2011 ("the public consultation exercise"). Based on the outcome of the consultation exercise which ended in February 2012, the Administration sets out the concepts and principles governing the framework of the System, which covers, among others, voluntary participation for both HCRs and HCPs; "patient-under-care" and "need-to-know" principles for data access of HCPs; a pre-defined scope of data sharing; identification and authentication of HCRs and HCPs; the governance of the System; and the provision of a versatile and technology-neutral legal framework and codes of practice ("CoP") to set out the operational and security requirements.

The Bill

5. The Administration introduced the Bill into the Legislative Council ("LegCo") on 30 April 2014 to establish the System, to provide for the sharing and using of data and information contained therein and the protection of the System, and to provide for incidental and related matters. The Bill covers, among others, the establishment of the System; the appointment, functions and powers of the Commissioner for the Electronic Health Record ("the eHR Commissioner"); registration of HCR and HCPs; giving of consents by HCRs for use of eHR by HCPs; use of eHR; procedures for use of eHR for research and statistics; interaction with the Privacy Ordinance; new offences specific to the operation of eHR sharing; appeal mechanism; access to card face data; and liability of Government and public officers.

The Bills Committee

6. At the House Committee meeting on 2 May 2014, Members agreed to form a Bills Committee to study the Bill. The membership list of the Bills Committee is in **Appendix I**.

7. Under the chairmanship of Hon Charles Peter MOK, the Bills Committee has held 22 meetings with the Administration. The Bills Committee has also received oral representation from 21 organizations and individuals at one of these

meeting, and met separately with the Privacy Commissioner for Personal Data ("the Privacy Commissioner") at three of its meetings. A list of organizations and individuals which/who have given views to the Bills Committee is in **Appendix II**.

Deliberations of the Bills Committee

Control of registered HCRs over data sharing

Proposals in the Bill

8. Under the Bill, any individual for whom healthcare has been performed, is performed, or is likely to be performed in Hong Kong, may apply to be registered under the System if the person holds an identity card as defined by section 1A(1) of the Registration of Persons Ordinance (Cap. 177), a certificate of registration of birth issued under the Births and Deaths Registration Ordinance (Cap. 174), a proof of identity or a certificate of exemption as defined by sections 17B(1) and 17G(1) of the Immigration Ordinance (Cap. 115) respectively, or any other identification document as specified by the eHR Commissioner. An HCR (or a substitute decision maker ("SDM") of an HCR) must give a joining consent to the eHR Commissioner when applying to be registered as a registered HCR. The joining consent allows the eHR Commissioner to obtain from, and to provide to, a prescribed HCP[1] any index data and health data ("sharable data") of the HCR, for the operation of the System[2]. A registered HCR (or an SDM of a registered HCR) may give a sharing consent to a prescribed HCP that provides healthcare to the HCR. The sharing consent allows the prescribed HCP to provide to, and to obtain from, the System any sharable data of the HCR. When a prescribed HCP needs to involve another prescribed HCP in the healthcare for an HCR, the sharing consent given to the first-mentioned HCP will cover a consent for the referral HCP to access the System for particular purposes relevant to the healthcare referral.

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[1] Under the Bill, the Department of Health ("DH"), the Hospital Authority ("HA"), an HCP that is registered as an HCP for the System for a service location, and a Government bureau or department that is registered as an HCP for the System are prescribed HCPs. For the purpose of registration for the System, HCP means a person that provides healthcare at one or more than one service locations. In practice, HCPs may include entities operating hospitals, medical clinics, dental business, and residential care homes or specified entities that engage members of the 13 statutorily registered healthcare professionals to perform healthcare.

[2] The eHR of a registered HCR in the System will comprise the index data (i.e. the personal particulars of the HCR that identify the HCR for the operation of the System, such as name, identity document number and gender); the health data of the HCR; and any other data or information of the HCR that is, in the eHR Commissioner's opinion, necessary for the proper functioning of the System.

9. The Bill also proposes that the above requirement for a prescribed HCP to obtain specific sharing consent from an HCR will not be applicable to DH and HA. Under clause 16 of the Bill, consent for DH and HA to provide and obtain the sharable data of a registered HCR through the System is taken to be given when a joining consent is given by the HCR.

Additional safeguards for registered HCRs' data privacy

10. A majority of members are of the strong view that given the sensitive nature of health data, registered HCRs should be provided with additional access control over the health data contained in their eHR such that the HCRs can exclude certain prescribed HCPs which/whom they have already given a sharing consent to, from access to certain parts of their health data. They are also concerned that the lack of enhanced protection over certain sensitive health data might result in discrimination against those HCRs suffering from particular diseases, such as mental illness. These members consider that a "safe deposit box" feature, which allows enhanced access control for certain health data, should be provided under the System as suggested by the Privacy Commissioner and a number of patient groups. While understanding that there is another view that introducing such a feature into the System would undermine the completeness and integrity of the eHRs of registered HCRs and affect the quality of healthcare provided by prescribed HCPs, these members stress the need to provide additional safeguards for the registered HCRs' data privacy in order to instil public confidence in the System. This apart, health data kept in the System could in no way be construed as a complete set of health record of the registered HCRs. It is incumbent upon the prescribed HCPs to exercise their professional judgement when using eHR as a clinical reference.

11. Prof Joseph LEE, however, takes the view that there is no need to provide a "safe deposit box" feature in the System which only serves as a platform for sharing health data within the sharable scope contained in the electronic medical record ("eMR") systems of prescribed HCPs to whom the registered HCRs have given sharing consent. The Bill does not seek to require the prescribed HCPs to surrender their intellectual property rights to the eHR Commissioner. Hence, registered HCRs are merely data subjects of the relevant health data kept in the System and the eMR systems of individual prescribed HCPs. He has further pointed out that participation of HCRs in the System is voluntary. In addition, registered HCRs need to give a separate sharing consent to particular HCPs they select, such that the HCPs could obtain their sharable data from the System.

12. The Administration has explained to the Bills Committee that the "safe deposit box" feature has no standard technical design. It is not an item within the project scope of the stage one eHR Programme. During the public consultation exercise, diverse views were received on the provision of a "safe deposit box"

feature under the System. When reporting the outcome of the public consultation to the Panel on Health Services of LegCo ("the Panel") in 2012, the Administration has already undertaken to conduct further study, making reference to overseas experience, on additional access control for sensitive health data during the second stage eHR Programme. In view of members' and the Privacy Commissioner's grave concerns over the matter, the Administration has further undertaken that the study would be conducted along a positive direction in the first year of the second stage eHR Programme after the passage of the Bill, with a view to developing and implementing some form of new device or arrangement so as to give additional choices for HCRs over the disclosure of their health data. Relevant stakeholders including the Steering Committee on Electronic Health Record Sharing, the Privacy Commissioner, medical professional bodies and patient groups, and the Panel would be consulted as appropriate on the proposed new feature upon the completion of the study.

13. Members in general recognize the need not to pre-empt the future design of the relevant technical feature at this stage. They, however, take the view that the spirit of fostering registered HCRs' choice over the scope of data sharing should be stated expressly in the legislation. The Bills Committee has considered a set of amendments to the Bill put forward by the Privacy Commissioner to such effect. After consideration, the Administration will move Committee stage amendments ("CSAs") to add a new Division 3A under Part 2 of the Bill, and a new definition of "sharing restriction request" for providing that a registered HCR may, in relation to his or her health data, make a request to restrict the scope of data sharing (or to remove such a restriction). It is proposed that the proposed new provisions should take effect only upon completion of the further study and after the relevant feature is technically ready for implementation.

14. The Bills Committee has written to organizations and individuals which/who have given views on the Bill to invite their views on the proposed amendments. They generally welcomed the proposal. Dr LEUNG Ka-lau has requested the Administration to ensure that the drafting of the CSAs would have the effect that the proposed new provisions would have effect notwithstanding clauses 12(6), 16 and other clauses in the Bill relating to sharing consent. The Administration has accepted the suggestion and revised the CSAs accordingly.

Requests by registered HCRs for not providing certain parts of their sharable data to the System

15. Members note that subject to the passage of the Bill in the first half of 2015, the Administration targets to commission the System in the latter half of 2015. In the light of the fact that the new feature enabling additional choice for HCRs over the disclosure of their health data will still be in its design stage when the System

is in operation, some members including Dr LEUNG Ka-lau and Dr KWOK Ka-ki have enquired whether registered HCRs could request the prescribed HCPs, to whom they have given sharing consent, not to provide to the System certain health data which falls within the pre-defined sharable scope.

16. The Administration has informed the Bills Committee that under the design or workflows of the System developed under the stage one eHR Programme and depending on the local eMR systems of prescribed HCPs, sharable data of a registered HCR that has been entered into the local eMR system of a prescribed HCP having the capability to interconnect with the System would be uploaded to the System with no exclusion. Clause 12(6) as currently drafted does not preclude a registered HCR from requesting the prescribed HCP not to provide certain parts of his or her sharable data to the System. The decision on whether to accede to the request would be left to the professional judgement of the healthcare professionals engaged by the HCPs, the particular clinical workflow of the HCPs and whether the local eMR system of the HCPs concerned is technically capable of doing so.

17. Dr LEUNG Ka-lau, however, remains concerned that clause 12(6) as currently drafted would result in a registered HCR not being able to hold a prescribed HCP responsible for providing any of his or her sharable data to the System despite the HCR has specifically requested the HCP not to do so, as a sharing consent has already been given to that HCP.

Sharing consent taken to be given

18. Some members including Dr LEUNG Ka-lau, Dr KWOK Ka-ki and Dr Fernando CHEUNG have expressed concern that in accordance with clause 16, consent for DH and HA to provide and obtain the sharable data of a registered HCR through the System would be taken to be given when a joining consent is given by the HCR. They have expressed doubt about the need for DH and HA to obtain from the System the sharable data of those registered HCRs who only use private (but not public) healthcare services. They have suggested that a new arrangement should be put in place to allow the registered HCRs to opt out from the proposed arrangement under clause 16.

19. The Administration does not support the suggestion as it is clearly not in line with the Administration's policy objective for the System, as a publicly funded platform, to foster public-private collaboration in healthcare delivery for the benefits of HCRs through the two-way sharing of eHR between public and private HCPs. According to the Administration, DH and HA, which are the HCPs of the public sector serving the largest number of HCRs in Hong Kong, possess vast amount of health data of HCRs. Their contribution to the System of registered HCRs' health data will form the essential building blocks of these

HCRs' lifelong eHRs. Without these health data, the content of eHR may be much more flimsy. The current proposal also facilitates the registration process and reduce the burden on HCRs, DH and HA. The Administration has advised that those HCRs who use only private (but not public) healthcare services and do not wish DH or HA to obtain their health records could choose not to join the System until the development and implementation of some form of new device or arrangement to enable additional choices for HCRs over the disclosure of their health data in the second stage eHR Programme.

20. The Administration has also pointed out that the above proposed arrangement had been put to consultation in the public consultation exercise. There are practical difficulties to modify the design of the System already developed under the stage one eHR Programme to accommodate requests for the opting out from this arrangement by HCRs. While not insurmountable, it is estimated that no less than 12 months would be required for substantial modification of the design of the System. The Administration does not envisage that the opt-out arrangement, even if it is decided to be implemented, would be technically available in the initial months of operation of the System. Members have in general raised no objection to the Administration's decision of retaining the proposed arrangement in the Bill.

Coverage of the joining and sharing consents

21. Clauses 12 and 16 as currently drafted will have the respective effect that the giving of a sharing consent and a joining consent by a registered HCR would enable the prescribed HCP to which the HCR has given a sharing consent, and DH and HA to obtain from, and also to provide to, the System any sharable data of the HCR.

22. Dr LEUNG Ka-lau takes the view that the combining of the indication of agreement to the prescribed HCPs' contribution to, and obtaining from, the System any sharable data of the registered HCRs under a single consent given by the HCRs would undermine privacy protection for the data subjects. He has pointed out that there may be cases whereby the registered HCRs would only wish to give consent to DH or HA to provide to (but not obtain from) the System their sharable data and allow a prescribed HCP in the private sector to access their sharable data, or vice versa. He has therefore suggested for consideration of the Bills Committee that the Bill should be amended to the effect that (a) the joining consent given by a registered HCR would only allow the eHR Commissioner to, for the operation of the System, obtain from all prescribed HCPs in the public and private sectors those sharable data falling within the scope of sharing so specified by the HCR; and (b) the sharing consent given by a registered HCR to an individual prescribed HCP would only allow the HCP to obtain from the System any of his or her sharable data.

23. The Administration has raised objection in principle to the suggestion on the grounds that the splitting of the sharing consent, which originally covers both uploading and viewing of the sharable data of the registered HCRs, has the effect of creating a one-way arrangement as a default setting. This would seriously undermine its policy objective to promote two-way sharing of eHR amongst public and private HCPs for the benefit of HCRs. The suggestion would completely alter the design principles and consent arrangement as put forward in the public consultation document, and render the System already developed under the stage one eHR Programme not operable. The Administration has also pointed out that its proposed CSAs to add new clauses 16A and 16B to provide that a registered HCR may, in relation to his or her health data, make a request to restrict the scope of data sharing already provide very flexible room to allow different methods of restrictions to be implemented in future, including arrangements to address the concern of Dr LEUNG Ka-lau and different potential scenarios. There is no point in further amending the Bill.

24. Dr KWOK Ka-ki is of the view that any proposal to enable the registered HCRs to have greater control over the scope of data sharing would instil confidence in the System. Some members including Ms Emily LAU have no particular views on Dr LEUNG Ka-lau's suggestion. There are other members including Mr CHAN Han-pan, Dr Elizabeth QUAT and Ir Dr LO Wai-kwok who have expressed agreement with the arguments put forward by the Administration. The Bills Committee, however, has not come to any unanimous view on the issue.

25. Dr LEUNG Ka-lau has indicated his intention to propose CSAs to the Bill for achieving the effect as set out in paragraph 22 above with a view to enhancing protection for data privacy of the registered HCRs.

The "need-to-know" principle

26. The Administration has informed the Bills Committee that, based on the outcome of the public consultation exercise, a principle governing the framework of the System is that health data in the System would not be used by or accessible to those without the need to know (or commonly referred to as the "need-to-know" principle). This principle has been adopted in the design of the System and its operational workflows, and reflected in the legislative proposal. Members, however, share the concern of the Privacy Commissioner and some other deputations that the proposed arrangement for the sharing consent be given by a registered HCR to an entity (such as a hospital, a medical or dental clinic, and a residential care home for the elderly), but not to its individual healthcare professionals (such as the registered medical practitioners or dentists, registered or enrolled nurses, and registered medical laboratory technologists), could not ensure that that the eventual access to the health data of the HCR would be on a

need to know basis. This is particularly so for the cases of DH and HA, as they have employed a large number of healthcare personnel and administrative staff, and the giving of a joining consent by an HCR would be taken as having given a sharing consent to the two HCPs. Members have also expressed concern that there is no express provisions stipulating that the access would be limited to those health data that would be relevant for performing healthcare for the HCR concerned. This will have the effect of enabling some prescribed HCPs, such as those performing the role of company doctors, to access more health data than necessary.

27. Members have also pointed out that the proposed arrangement is different from the existing arrangement adopted by the Public Private Interface - Electronic Patient Record Sharing Pilot Project whereby the one-way access to an HCR's records in HA is granted to specified healthcare professionals. They have suggested that provisions should be added to the legislation to the effect that among the staff employed by a prescribed HCP with sharing consent, only relevant healthcare professionals could have access to the relevant parts of eHR kept in the System.

28. After consideration of members' views, the Administration has agreed to move CSAs to add a new clause 35A such that it is the duties of a prescribed HCP to take reasonable steps to ensure that access to any health data of an registered HCR is restricted to a healthcare professional of the HCP concerned who may perform healthcare for the HCR, and the access is restricted to the health data that may be relevant for performing healthcare for the HCR, in order to reflect the "need-to-know" principle more expressly.

29. At the suggestion of the Privacy Commissioner, the Administration has further proposed under the new clause 35A(3) that, for complying with a data access or correction request under Part 5 of the Privacy Ordinance, the HCP concerned is not to be treated as contravening the above requirement even if access to the health data is granted to a person other than the healthcare professional. This is to cater for circumstances where administrative staff of a prescribed HCP that handle data access or correction requests may need to access the personal data in the System of a registered HCR.

30. The legal adviser to the Bills Committee has enquired whether there is also a need to provide for access to personal data in the System by a person other than the healthcare professional in the employ of a prescribed HCP for the purpose of erasing personal data no longer required or keeping a log book under sections 26 and 27 of the Privacy Ordinance respectively. The Administration has advised that it is the responsibility of the eHR Commissioner, instead of the prescribed HCPs, to erase health data of registered HCRs in the System. The eHR Commissioner, as a data user, is also responsible for the keeping of a log book for

the System. It does not envisage any operational need to provide for access to personal data in the System purely for the purpose of keeping a log book by the HCPs. There is no need to revise the new clause 35A(3) as clause 48 of the Bill has provided that the eHR Commissioner may appoint a person in writing to assist him or her in performing a function or exercising a power.

31. The Bills Committee has written to organizations and individuals which/who have given views on the Bill to invite their views on the proposed amendments discussed in paragraphs 28 and 29 above. They generally welcomed the proposal. There is a view that adequate technical support and guidance should be provided to individual prescribed HCPs in performing the duties in relation to restrict access to sharable data.

The SDM arrangement

Proposals in the Bill

32. The Bill seeks to introduce a SDM arrangement to facilitate the registration of those HCRs who may not have the capacity to understand eHR sharing or provide an express joining or sharing consent. It is proposed that in the case of a minor (i.e. a person below 16 years of age as defined under the Bill), in the order of priority, (a) a parent, or a guardian appointed under or acting by virtue of the Guardianship of Minors Ordinance (Cap. 13) or otherwise appointed by the court, or a person appointed by the court to manage the affairs of that HCR, who accompanies[3] the HCR at the relevant time; or (b) in the absence of the above persons, an immediate family member of the minor who accompanies him or her at the relevant time, may act as his or her SDM.

33. It is further proposed that in the case of a person who is mentally incapacitated as defined by section 2(1) of the Mental Health Ordinance (Cap. 136), incapable of managing his or her own affairs, or incapable of giving a joining consent or a sharing consent at the relevant time, in the order of priority, (a) a guardian appointed under the Mental Health Ordinance who accompanies the HCR at the relevant time, or the Director of Social Welfare ("DSW") or any other person under which guardianship of the HCR is placed, or DSW in which guardianship of the HCR is vested, or DSW or any other person performing functions of a guardian, or a person appointed by the court to manage the affairs of the HCR who accompanies the HCR at the relevant time; or (b) in the absence of the above persons, an immediate family member of the person who accompanies him or her at the relevant time, may act as his or her SDM.

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[3] According to the Administration, "accompanies" in the Bill includes the element of physical presence to facilitate proper authentication and recording of the identity of the SDM.

34. It is proposed that, for both cases of a minor or a person who is mentally incapacitated, incapable of managing his or her own affairs, incapable of giving a joining or sharing consent at the relevant time, if none of the above persons is available, as a last resort, a prescribed HCP that provides, or is about to provide, healthcare to the HCR concerned at the relevant time may act as his or her SDM.

Persons covered under the definition of "immediate family member"

35. Some members including Ms Cyd HO, Dr Fernando CHEUNG and Dr Helena WONG are of the view that the definition of "immediate family member" in the Bill should not be limited to an individual who is related to an HCR by blood, marriage, adoption or affinity. They have suggested that the definition should be expanded to the effect that a cohabitee living with an HCR can act as an SDM of an HCR. Referring to the Chinese rendition of the expression "immediate family member" which is "家人", members have suggested that the Chinese and English expressions should be aligned to achieve consistency.

36. After consideration, the Administration has agreed to take on members' suggestions and will move CSAs to the definition to the effect that a person residing with the HCR who accompanies the HCR at the relevant time may also act as the SDM of the HCR concerned. The Administration will move further CSAs to amend the English text of the expression "immediate family member" in clauses 2(1), 3(2)(d) and 3(4)(f) of the Bill to "family member".

HCPs serving as a last resort

37. Dr LEUNG Ka-lau has suggested that in the event that there are disputes among the family members of a registered HCR, the SDM arrangement should follow the existing decision-making arrangement for carrying out medical treatments without the consent of an HCR or that HCR's family member(s). This in effect means that a prescribed HCP that provides, or is about to provide, healthcare to the HCR at the relevant time could decide on the HCR's behalf whether the registration (or the withdrawal of a registration), or the giving of the joining or sharing consent (or the renewal or revocation of a sharing consent) is necessary and is in the best interest of the HCR concerned.

38. According to the Administration, it is anticipated that for most cases where an eligible SDM make a joining or sharing consent decision on behalf of an HCR, the circumstances involved would not be an emergency situation. Hence, when there are disputes among the immediate family members of that HCR, they could take their time to discuss among themselves and resolve such disputes. The Administration considers it appropriate to retain the proposed arrangement, which had been put to consultation in the public consultation exercise, that a

prescribed HCP serves as a last resort in giving a joining or sharing consent on behalf of the HCR in the absence of other eligible persons.

39. The Administration has informed the Bills Committee that for cases where emergency access to a registered HCR's eHR in the System is necessary in tandem with the carrying out of emergency treatments on that HCR, the HCP concerned could access the eHR on a temporary basis without the data subject's consent by virtue of section 59 and/or section 63C of the Privacy Ordinance. The SDM arrangement needs not come into play in such context. When making such an access, the HCP concerned would need to provide justifications for the access, which would be logged in the System and subject to audit.

40. The legal adviser to the Bills Committee has enquired whether sections 59 and 63C of the Privacy Ordinance could in fact cover the urgent need for obtaining eHR in the run of the mill, yet emergency, treatments of patients and whether there is a need to provide for an express exemption to cover this scenario. The Administration has advised that the term "emergency treatments" is regarded as covering generally actions in those situations where non-disclosure of the eHR of the HCR concerned would likely to cause serious harm to his or her physical or mental health and/or would be likely to prejudice the carrying out of medical relief services to him or her during emergency. Depending on the facts and circumstances of the individual case, the HCP concerned could access the eHR concerned without the HCR's consent by invoking the exemption under data protection principle 3 under section 63C and/or section 59 of the Privacy Ordinance. Given that exemptions under sections 59 and 63C of the Privacy Ordinance are already sufficient for the purpose of allowing access to eHR by healthcare professionals under emergency situations, the Administration does not see the need to add another exemption clause in the Bill.

41. Separately, Dr Fernando CHEUNG has doubts as to whether the interest of those elderly persons who were incapable of managing their own affairs or giving a joining or sharing consent at the relevant time would be undermined as the Bill imposed no obligation on eligible SDM, in particular their HCPs, to take action on their registration.

42. The Administration has explained that it is not appropriate, nor practicable, to stipulate in the Bill that a particular SDM would be obliged to make a decision for an HCR as participation in the System is voluntary. That said, it is envisaged that many residential care homes, which are eligible to be registered as HCPs for the System under clause 17(5) of the Bill, would have keen interest in joining the System and encouraging the elderly HCRs under their care to join the System, as eHR could help them better take care of their residents. The Administration has undertaken to conduct intensive promotion, targeting on the residential care homes for the elderly, to encourage participation of the System by the elderly HCRs residing therein.

The role of the Guardianship Board

43. Dr Fernando CHEUNG has suggested that the Guardianship Board should accept application from a family member of a mentally incapacitated person for appointment as that person's guardian to deal with matters relating to the participation of the System such as the joining of the System and giving of sharing consent to particular HCPs. This could minimize the dispute caused by different family members of that mentally incapacitated person holding different views on whether to give such consents under the System. As an alternative, any such disputes should be referred to the Guardianship Board for resolution. The Administration has advised that participation in the System, which is voluntary, is not a matter with welfare implications significant to the extent of falling within the intended circumstances for the granting of a Guardianship Order under the Mental Health Ordinance. For similar reasons, resolving disputes of this nature is not in line with the role of the Guardianship Board under that Ordinance.

Registration as an HCP

44. Clause 17(5)(g) of the Bill seeks to allow the registration as an HCP for the System by a specified entity that, in the opinion of the eHR Commissioner, directly or indirectly provides healthcare to any HCR. Members share the concern of the Privacy Commissioner that the proposed arrangement was too loose which would in effect widen the sharing of the data and information contained in the eHR of a registered HCR.

45. The Administration has also informed the Bills Committee that clause 20 which provides that the eHR Commissioner may register a Government bureau or department (not include DH) that involves providing healthcare, is drafted mainly to cater for certain Government departments such as the Immigration Department and the Correctional Services Department which provides healthcare to detainees. While members in general agree the need to make such a provision, they share the concern of the Privacy Commissioner that the proposed criteria for registering a Government bureau or department as an HCP for the System is too loose when compared to the criterion for registration by a specified entity (i.e. engaged a healthcare professional to perform healthcare at one premises) as set out in clause 17(5)(f). They have proposed that similar criterion on the provision of healthcare should be adopted for the registration.

46. The Administration is in agreement and will move CSAs to delete clause 17(5)(g), and amend clause 20 to the effect that the eHR Commissioner may register a Government department as a HCP for the System if he or she is satisfied that the department provides a healthcare professional to perform healthcare for

any HCR. The Bills Committee has written to organizations and individuals which/who have given views on the Bill to invite their views on the proposed amendments and no objection was received.

Suspension or cancellation of registration of HCR and HCP

Suspension period

47. Clauses 10(1) and 11(1) as well as clauses 22(1) and 23(1) of the Bill respectively provide that the eHR Commissioner may, under the circumstances specified, suspend or cancel the registration of an HCR and an HCP if the eHR Commissioner reasonably suspects that, or is satisfied that, certain events have occurred. Some members express concern that the suspension period should not be indefinite and the eHR Commissioner should decide whether to proceed with cancellation or not within a certain timeframe.

48. The Administration has taken the view that the eHR Commissioner would not unduly prolong the suspension period given the requirement under Section 70 of the Interpretation and General Clauses Ordinance (Cap. 1) which stipulates that "where no time is prescribed or allowed within which any thing shall be done, such thing shall be done without unreasonable delay, and as often as due occasion arises". Members in general do not subscribe to the Administration's view. They remain their view that a time limit of the suspension period should be provided for in the Bill.

49. After consideration of members' view, the Administration will move CSAs to amend clauses 10(1) and 22(1), and add new clauses 10(1A) and 22(1A) to the effect that the eHR Commissioner may suspend the relevant registration initially for a period of not more than 28 days. The suspension may be extended once for a further period of not more than 28 days if the eHR Commissioner considers it appropriate. The Administration has informed the Bills Committee that in formulating the above proposal, due regard had been made to the technical complexity of the System and the need to allow sufficient time for resolving the circumstances that trigger the suspension or to assess whether further action of cancellation is warranted.

Representation by HCR or HCP before suspension or cancellation of registration

50. The Administration has informed the Bills Committee that it is envisaged that before the eHR Commissioner exercises the power of suspension or cancellation of registration, he or she will take administrative actions as appropriate to seek information or clarification from the HCR or HCP concerned. The eHR Commissioner has to reasonably suspect or be satisfied that the circumstances as stipulated in clauses 10(1), 11(1), 22(1) or 23(1) have occurred.

In other words, it will likely be a two-way interactive process during which the HCR and HCP concerned will be timely informed of the possible suspension or cancellation, and they can provide information or clarification to the eHR Commissioner before his or her final decision. The Administration has further pointed out that, under certain circumstances, prompt action to suspend or cancel the registration of an HCR or HCP will be necessary.

51. Members are of the view that, in order to ensure procedural justice, the Administration should make express provisions in the Bill to provide that the HCR and HCP concerned would be given an opportunity to make representation before the eHR Commissioner make a decision on whether or not to suspend or cancel their registration. The Administration has advised the Bills Committee the possible security scenarios which warrant immediate suspension. While maintaining its position that there is no need to provide for the making of representation by an HCR or an HCP against a decision of suspension of their registration, the Administration takes the view that there are justifications for a different arrangement for cancellation vis-à-vis suspension cases. The Administration will therefore move CSAs to amend clauses 11(2) and 23(2), and add new clauses 11(2A), 11(2B), 23(2A) and 23(2B) to provide that an HCR or HCP may make representations to the eHR Commissioner to object to the cancellation before the eHR Commissioner makes a decision on cancellation of registration of the HCR or HCP concerned.

Circumstances that constitute impairing the security or compromising the integrity of the System

52. Members note that under clauses 10(1)(d), 11(1)(d), 22(1)(e) and 23(1)(e), the eHR Commissioner may suspend or cancel the registration of an HCR or a registered HCP if the eHR Commissioner is satisfied that the registration may impair the security or compromise the integrity of the System. Members are of the view that express provisions should be made in the Bill to provide for the factors which the eHR Commissioner would have to take into account in deciding whether a registration should be suspended or cancelled on the above grounds.

53. The Administration has explained to the Bills Committee that it is neither desirable nor feasible to exhaustively list out possible factors in the Bill. For an HCR, it could be the HCR using fraudulent identity document for registration, using multiple identity documents to register at different points in time, or not informing the eHR Commissioner on changes of personal particulars, among others. For an HCP, it could be the HCP not following security best practices and controls for its local eMR system (such as physical control and installation of active anti-virus or anti-malware software with up-to-date definitions) or not suitably following up on a suspected security incident that affects the use of or connection with eHRSS, among others. The Administration assures members

that it will suitably promulgate guidelines and conduct publicity to promote HCRs' and HCPs' understanding of relevant precautionary steps and security measures.

54. As a related issue, members consider clause 35 which requires a prescribed HCP to take reasonable steps to ensure that the HCP's eMR system does not impair the security or compromise the integrity of the System unnecessary as the above requirement should be covered in detail in a code of practice ("CoP") to be issued by the eHR Commissioner under clause 51. They also note that a mechanism has already been provided for in clauses 22(1)(a)(ii) and 23(1)(a)(ii) that the eHR Commissioner may, under the circumstances specified, suspend or cancel the registration of an HCP if the eHR Commissioner suspects or is satisfied that the HCP concerned contravenes a provision of a CoP issued under clause 51. They have suggested to the Administration to delete the clause. Taking into account that the deletion of the clause would not affect the operation of clauses 22(1)(e) and 23(1)(e), the Administration is in agreement and will move CSAs to delete clause 35, and propose corresponding amendments to the title of Division 4 of Part 3 of the Bill.

Use of information and data in the System for improving the healthcare performed outside Hong Kong

Geographical restriction in respect of the location of the healthcare performed

55. The Bill seeks to specify that only those HCPs providing healthcare at service locations in Hong Kong could apply to the eHR Commissioner to be registered as HCPs for the System for that location. Any access to the System for the purpose of using the data of a registered HCR for improving the efficiency, quality, continuity or integration of the healthcare provided, or to be provided, to the HCR, as well as the concerned use of the concerned data, have to be by a healthcare professional registered under relevant ordinances in Hong Kong. It is proposed under the definition of "healthcare" in the Bill that, in relation to an individual, the healthcare activity has to be performed in Hong Kong by a healthcare professional for the individual.

56. Members have expressed concern that the above geographical restrictions might prejudice the interests of HCRs when there is a genuine need for them to obtain eHR for reference when receiving healthcare outside Hong Kong.

57. The Administration has explained to the Bills Committee that local legislations and system requirements of the System could not be enforced outside Hong Kong. For security and privacy reasons, it is proposed under the Bill that only those HCPs providing healthcare at service locations in Hong Kong could apply to the eHR Commissioner to be registered as HCPs for the System for that

location. The Administration has pointed out that in case a registered HCR wishes to show his or her health records kept in the System to an overseas HCP, he or she could approach the eHR Commissioner's Office to make a data access request concerning the records and forward the copy of such records to the overseas HCP.

58. While members consider the imposition of the geographical restriction that the registered service location of HCP has to be in Hong Kong and the requirement for its healthcare professional to be statutorily registered in Hong Kong acceptable from the policy point of view, they have requested the Administration to consider the situation where access to the System from overseas under certain special circumstances for healthcare purpose, such as facilitating a healthcare professional registered in Hong Kong providing urgent medical advice to a registered HCR when the former is travelling abroad, is required. This apart, there may be cases that prescribed HCPs would provide the health data of a registered HCR to another HCP outside Hong Kong for improvement of healthcare performed outside Hong Kong. They have suggested that, in order to safeguard the interest of HCRs, access to the System by a healthcare professional registered under relevant ordinances in Hong Kong for the purpose of using the data and information of a registered HCR for improvement of healthcare performed outside Hong Kong should be allowed.

59. The Administration has taken on board members' view and will move CSAs to amend the definition of "healthcare" in clause 2(1) to remove the restriction that the healthcare has to be performed tin Hong Kong. This would allow access to the System for healthcare in overseas under certain special circumstances.

60. In the light of the above proposed arrangement, members are concerned about the implications of section 33 of the Privacy Ordinance, which has not yet commenced, on the operation of the Bill. They note that the provision prohibits a data user to transfer any personal data to places outside Hong Kong except in specified circumstances. At the invitation of the Bills Committee, the Privacy Commissioner has advised that section 33 of the Privacy Ordinance would come into play if the System is accessed by registered HCPs outside Hong Kong and the health data of a registered HCR in the System is disclosed to an overseas HCP, and the HCPs concerned might, where appropriate, invoke the various exceptions as provided for under section 33(2) of the Privacy Ordinance when the provision comes into operation. Members take the view that the sharing of health data in the System to an overseas HCP for life-saving purpose as proposed in the Bill should not be prejudiced when section 33 comes into operation. The Administration has also undertaken that it would observe the requirements under section 33 of the Privacy Ordinance when the provision comes into operation.

Healthcare provided by a healthcare professional not registered in Hong Kong at a overseas HCP

61. Members have enquired about the availability of a mechanism for uploading to the System of the health data of those registered HCRs who received healthcare provided at a overseas HCP by a healthcare professional not registered in Hong Kong.

62. The Administration has advised that healthcare professionals have responsibility to maintain accurate and up-to-date medical records of their HCRs. In the event that a registered HCR requests a prescribed HCP to upload certain health information provided by other HCPs (including an overseas HCP), the healthcare professional concerned should make a professional judgement on whether the request of that HCR should be acceded to. When a healthcare professional started inputting a registered HCR's information into his or her eMR system, and with the HCR's sharing consent, those data within the sharable scope would be uploaded to the System.

Requirements for accessing the System

63. Members note that given that the Bill has not stipulated that prescribed HCPs could only access the System at the service location registered with the eHR Commissioner, a prescribed HCP to which the registered HCR has given a sharing consent could access the eHR of the HCR kept in the System at a location other than the registered service location. Dr LEUNG Ka-lau is concerned about the security requirements for a prescribed HCP to, where necessary, access the workstation at his or her service location remotely from other computers or mobile devices (through the use of remote desktop software or applications) for accessing the System.

64. The Administration has advised that the connection between individual eMR system or user workstation of prescribed HCPs with the System is restricted through registered and pre-defined connection modes. Prescribed HCPs can connect their own eMR system or workstation (which could be notebook) with the System through identifiable sources, i.e. Virtual Private Network, or a fixed Internet Protocol address, or with the eHR Encapsulated Linkage Security Application. Connection from certain mobile device (such as smart phone) with the System direct is currently not supported. It is, however, technically possible for prescribed HCPs to access to the System using mobile devices through their eMR systems subject to compliance with security requirements defined by the eHR Commissioner.

65. As a related issue, some members including the Chairman, Ms Emily LAU, Dr LEUNG Ka-lau and Dr Elizabeth QUAT are of the view that the

Administration should actively engage the private information technology ("IT") sector in the development of the clinical management systems ("CMS") for prescribed HCPs to connect to the System. While the Government could develop systems for private HCPs to adopt, its major role should be providing the data sharing standard, interface specifications and interoperability requirements for connection to the System openly and maintaining a level playing field.

66. The Administration has informed the Bills Committee that the Government's policy is to provide facilitation for different CMS used by individual HCPs to connect to the System. The purpose of providing Government-developed software (i.e. CMS on-ramp) is to provide a low investment means for HCPs to connect to the System. Use of the software is not mandatory. The Administration has been providing, and has undertaken to continue to provide information on data sharing standards, interface specifications and interoperability requirements to facilitate those private HCPs using non-government developed systems for connection to the System. The Administration has pointed out that for popular systems in the market used by private clinics, it has been working very closely with vendors or providers to discuss their connectivity to the System. Action plans have been formulated for certain common commercial systems and also the CMS 3.0 of the Hong Kong Medical Association, the Dental Clinic Management System of the Hong Kong Dental Association, CMS of the University Health Service of Hong Kong Polytechnic University, etc.

Use of data of an HCR contained in eHR for carrying out research

Proposals in the Bill

67. Under the Bill, both identifiable and non-identifiable data[4] of a registered HCR contained in the eHR may be used for carrying out research, or preparing statistics, that are relevant to public health or public safety. Any application for uses of the data for the above purposes would require the submission of a written proposal setting out the nature and objectives, the anticipated public or scientific benefit and any other information specified by the eHR Commissioner. The applications for use of identifiable and non-identifiable data would be considered by the Secretary for Food and Health ("SFH") and the eHR Commissioner respectively.

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[4] Under the Bill, any data or information of an HCR is identifiable data if the identity of the HCR is ascertainable from the data or information. Any data or information of an HCR is non-identifiable data if the identity of the HCR is unascertainable from the data or information.

The use of identifiable data

68. Members in general have expressed concern as to whether there are sufficient privacy safeguards under the Bill in relation to the use of identifiable data of a registered HCR for research or statistics purpose. Some members consider that separate consent from the data subjects concerned should be obtained where practicable.

69. According to the Administration, the Electronic Health Record Research Board ("the eHR Research Board") established under clause 53 of the Bill would assess the applications involving identifiable data, having given due regard to the considerations set out in clause 31(2) which are in line with local and international practices on the use of identifiable medical data, and provide SFH with recommendations on whether to approve the applications, and if so, the approval conditions. The approval conditions might include special requirements on safeguarding privacy. Clause 45 of the Bill provides that a person commits an offence if the person knowingly contravenes a condition for use of the eHR data for research or statistics purpose imposed under clause 32(1)(a). In addition, any result or published material of the research must not contain any identifiable information.

70. At the suggestion of members, the Administration has undertaken to formulate a separate set of detailed guidelines for the eHR Research Board in consideration of an application, with reference to local and overseas practices. Members also consider that, in order to ensure that the 10 non-ex officio members of the eHR Research Board to be appointed by SFH would be drawn from various fields, the specific membership requirements for the Board should be set out in the Bill. The proposal has been put to organizations and individuals which/who have given views on the Bill and received support.

71. To address members' concern, the Administration will move CSAs to add a new subclause (2A) to clause 53 such that only persons who, in the opinion of SFH, are having expertise or experience in healthcare, privacy protection, statistics, research, law or IT; representing the interests of HCRs; or having other experience that would render the persons suitable for the appointment would be appointed as non-ex officio members of the eHR Research Board. The Administration has also accepted the suggestion of the legal adviser to the Bills Committee to provide express provisions on the term of appointment and re-appointment of members, and the circumstances under which the members of the Board may be removed from the office. The Administration will move CSAs to amend subclause (3) and add new subclauses (3A), (5A) and (5B) to clause 53 accordingly.

72. At the request of Ms Emily LAU, the Administration has undertaken to meet with the Hong Kong Alliance for Rare Diseases to explain the safeguards under the Bill in relation to the use of identifiable data of a registered HCR for research or statistics purpose.

Re-identification risk of the non-identifiable data

73. Some members including the Chairman have expressed concern on re-identification risk of the non-identifiable data of a registered HCR contained in eHR being used for research or statistics purpose. The Administration has explained to the Bills Committee that fulfilling the requirements in the Bill in relation to non-identifiable data as provided for in clause 2(2) will involve more than merely removing the personal identifiers of a particular record. In the process of de-identification, careful review of the eHR would be conducted to remove any data that would pose the risk of re-identification as far as possible.

Using eHR for research or statistics purpose without the data subject's consent

74. Members have raised concern about the liability for the use, without the data subject's consent, of another person's data or information contained in eHR for research or statistics purpose. The Administration has informed the Bills Committee that section 62 of the Privacy Ordinance provides that personal data is exempt from the requirement under data protection principle 3 for "prescribed consent" where (a) the data is to be used for preparing statistics or carrying out research; (b) the data is not to be used for any other purpose; and (c) the resulting statistics or results of the research are not made available in a form which identifies the data subjects or any of them. The Administration has additionally set out in the Bill a due process to consider applications for such uses of eHR. In brief, against the common practices that consent of research subjects should normally be obtained except under certain circumstances, clause 31(2) sets out the considerations that the eHR Research Board must have regard to when making a recommendation on whether the application for use of identifiable data should be approved. These considerations are in line with local and international practices on the use of identifiable medical data.

<u>Use of eHR permitted by or under any other law</u>

75. Clause 29 of the Bill provides that the data and information of HCRs contained in the System may be used "as permitted by, or under, any other law". Members note that "law" means "any law for the time being in force in, having legislative effect in, extending to, or applicable in, Hong Kong" under section 3 of the Interpretation and General Clauses Ordinance. Some members have raised queries over the need for the clause and scope of the coverage.

76. The Administration has advised that it is necessary to retain the clause. Given the general prohibition imposed by clause 25 on use of the data and information contained in the System, clause 29 serves to preserve the status quo of the prevailing uses of data and information pursuant to the legal regime at any point in time. The Administration further advises that as the law of Hong Kong is evolving over time to cope with the changing circumstances, the scope (and the purposes) under which the use of data and information in the System is required or permitted by law would vary. It is, therefore, appropriate to set out the general rule that the data and information of HCRs contained in the System may be used as permitted by, or under, "any other law". In addition, all uses pursuant to clause 29 will be governed, and safeguarded against abuse, by the relevant laws.

Access to and correction of data or information contained in eHR

Patient portal

77. Members note that according to the Privacy Ordinance, a data subject can make a data access request for a copy of his or her personal information held by the data users. The Privacy Ordinance also specifies that the data user may charge a fee which is not excessive to comply with a data access request. Registered HCRs, as the data subjects of the relevant personal data held under the System, could put forward data access request under the Privacy Ordinance. In response to members' enquiry about the fees to be charged on registered HCRs making such request, the Administration has advised that given that the information stored in the System is in electronic form, it is anticipated that the data access request fee for data kept in the System will not be substantial.

78. Members have requested the Administration to provide a patient portal in the System to facilitate registered HCRs to more conveniently access or upload their data to the System. The Administration has undertaken to conduct a study on the setting up of a patient portal in the first year of the stage two eHR Programme, with a view to striking a proper balance between the convenience of HCRs' access and data security.

Data access request by a person authorized in writing

79. Clause 38 of the Bill is drafted to the effect that a third party could not on behalf of a registered HCR make a data access request in respect of his or her data and information kept in the System, even if the HCR concerned provides the person with an authorization in writing. Members queried the need for the legislation to apply a more stringent standard than the current Privacy Ordinance over data access as pointed out by the Privacy Commissioner. Under sections 17A and 18 of the Privacy Ordinance, a person authorized in writing by the data subject could make a data access request on behalf of the data subject. Hence, a

person authorized in writing by a HCR could on behalf of the HCR concerned make a data access request to a HCP which holds the personal data of that HCR. They are particularly concerned that the above inconsistent arrangement under the Privacy Ordinance and the Bill would cause confusion to members of the public. Dr KWOK Ka-ki and Dr Fernando CHEUNG have pointed out that the proposal does not cater for the scenario of a registered HCR in serious illness who has difficulties to make such a request in person.

80. The Administration has explained that the proposed arrangement is to address the concern raised by certain quarters of the community over possible malpractice of unscrupulous employers or insurance companies trying to improperly obtain the written authorization from registered HCRs seeking employment or taking out insurance policy by coercive means in order to gain access to their eHR, when the health data so obtained is in fact more than necessary for the purpose concerned. The Administration has also informed the Bills Committee that in practice, the submission of a completed form duly signed by a registered HCR would suffice for making a data access or correction request. The Administration is, however, open to views as to whether the proposal should be retained or not because it is essentially a question of striking a balance between the need to provide more channels of access of eHR and the need to safeguard the data privacy of the registered HCRs.

81. The Bills Committee has discussed the relevant issues with the Privacy Commissioner. Members note from the Privacy Commissioner that a person commits an offence under section 18(5) of the Privacy Ordinance if the person, in making a data access request, supply an information which is false or misleading in a material particular for the purpose of having the data user informed the person whether the data user held any personal data which is the subject of the request, or having the data user supplied a copy of the data. While the circumstances of each case vary from one to other, it is envisaged that an authorization obtained by threat, coercion or misrepresentation is unlikely to be a valid authorization and in such circumstance, the requirement to make a data access request under section 18(1) of the Privacy Ordinance could not be satisfied. In response to members' enquiry about the handling of a data correction request under the System, the Administration has advised that such request would be handled by the prescribed HCP from which the health data originated. The HCP concerned, being the data user, might correct the data, or refuse to do so if it is not satisfied that the data to which the request related is inaccurate. The HCP concerned should make a note of the matter according to the Privacy Ordinance.

82. Members including Ms Emily LAU, Dr LEUNG Ka-lau, Dr KWOK Ka-ki and Dr Fernando CHEUNG consider that there is no need to retain the clause, as adequate safeguards against the making of a data access request by dishonest persons through improper obtaining of authorization from a data subject are

already in place. Mr Alan LEONG takes the view that the right for a registered HCR to authorize a third party to make a data access or correction request on his or her behalf should not be deprived of merely due to the concern that there might be possibility of abuse of the arrangement by dishonest persons.

83. Having considered the views of members, the Administration has agreed to drop the proposal from the Bill and will move a CSA to delete clause 38 accordingly. The Bills Committee has written to organizations and individuals which/who have given views on the Bill to invite their views on the CSA. They have raised no objection to the proposed deletion.

The making of the requests by a parent for a mentally handicapped child who is not a minor

84. Dr Fernando CHEUNG has expressed concern that it is beyond the Guardianship Board's jurisdiction to grant an order to enable parents to become guardians of their mentally handicapped grown-up children who did not fall within the definition of "mentally incapacitated person" in the Mental Health Ordinance for the purpose of making a data access or correction request in respect of their children's eHRs and the mentally handicapped grown-up children do not have the capacity to authorize their parents to do so. He considers that the Bill should be amended to the effect that a parent could make these requests on behalf of their mentally handicapped child who are not a minor.

85. The Administration has advised that the making and handling of such requests are generally governed by the Privacy Ordinance. A parent, unless he or she falls within the meaning of "relevant person" under the Privacy Ordinance[5], could not make a data access or correction request on behalf of his or her child. The issue at stake, which is how parents could assist in making of a data access or correction request in respect of the personal data held by various data users (the eHR Commissioner being one of them) of their grown-up children who suffer from mental illness, should therefore be considered in a wider context as there might be read-across implications in areas other than the operation of the System.

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[5] "Relevant person", in relation to an individual (howsoever the individual is described), means -
(a) where the individual is a minor, a person who has parental responsibility for the minor;
(b) where the individual is incapable of managing his own affairs, a person who has been appointed by a court to manage those affairs'
(c) where the individual is mentally incapacitated within the meaning of section 2 of the Mental Health Ordinance, (i) a person appointed under section 44A, 59O or 59Q of that Ordinance to be the guardian of that individual; or (ii) if the guardianship of that individual is vested in, or the functions of the appointed guardian are to be performed by, DSW or any other person under section 44B(2A) or (2B) or 59T(1) or (2) of that Ordinance, DSW or that other person.

Offences relating to accessing, damaging or modifying eHR data

Proposals in the Bill

86. Members note that the act of knowingly causing a computer[6] to perform a function (such as by means of hacking) so as to obtain unauthorized access to data or information contained in eHR, or knowingly damaging the data or information contained in eHR without lawful excuse would constitute an offence under clause 41 of the Bill.

87. Clause 41 also seeks to criminalize a person who (a) knowingly causes access to, or modification of, or impairment to the accessibility, reliability, security or processing of, data or information contained in the eHR; and (b) causes the access, modification or impairment with intent to commit an offence, or with a dishonest intent to deceive, or with a view to dishonest gain for the person or for another, or with a dishonest intent to case loss to another, whether on the same occasion as the person causes the access, modification or impairment or on any future occasion.

Unauthorized access by means other than the use of a computer

88. The Privacy Commissioner has suggested to the Bills Committee that unauthorized access by means other than the use of a computer, such as a non-healthcare professional of a prescribed HCP's viewing of the health data of a registered HCR when a healthcare professional of that HCP has failed to log out from the System, should be made an offence. The Privacy Commissioner has pointed out that during the public consultation for the review of the Privacy Ordinance in 2009, a more stringent regulatory regime for sensitive personal data (including health data) was proposed but the proposal was not taken forward by the Administration. One of the reasons was that there were no mainstream views in the community on the scope of sensitive personal data. The Privacy Commissioner is of the view that there should be little argument that health data of a registered HCR is sensitive in nature.

89. The Administration has advised that the System is an IT system, to which access is mainly through computer. It is of the view that data and information not directly obtained from the System should not be governed by any offence provision under the Bill. In addition, unauthorized access to the System alone by non-computer means may not be a premeditated act under certain circumstances. To criminalize the mere act of unauthorized access not followed by any malicious act could arguably be disproportionate. If it is considered that unauthorized

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[6] "Computer", in the context of clause 41 of the Bill, means a device for storing, processing or receiving data or information.

access of personal data without subsequent malicious act in general should be criminalized, amending the Privacy Ordinance would be more appropriate in the light of the across-the-board implications. The Administration has undertaken that once the Privacy Ordinance is amended to such effect, a review of the Ordinance (if enacted) would be conducted accordingly.

90. Members have expressed diverse views on the Privacy Commissioner's suggestion. Some members have expressed reservations about the suggestion. They consider it necessary to strike a proper balance between the interests of the data subjects and data users in determining as to how far the data and information contained in eHR should be protected. They also note that the mere act of assessing a person's personal data without consent is not an offence under the Privacy Ordinance. Some other members are, however, of the view that the unique arrangement of data sharing under the System has made it necessary for additional privacy safeguards in order to instil the confidence of HCRs in the System. They are concerned that the wrongdoing of unauthorized access to the data and information contained in eHR without subsequent malicious act might not be as innocent as it seemed to be, as it might be the intention of the person concerned to keep the data concerned for some unknown future use.

91. Separately, the organizations and individuals which/who have responded to the Bills Committee's invitation for views on the suggestion have raised no particular views in this regard. Given the diverse views expressed by members, the Bills Committee has decided not to pursue the issue further.

Offences proposed under Clause 41(6)(b)

92. Members note that clause 41(6)(b) is modeled on section 161 of the Crimes Ordinance. The Chairman has expressed concern about the increasing number of prosecutions cases pertaining to section 161 of the Crimes Ordinance. He takes the view that the above provision of the Bill, if enacted, should be invoked for handling cases involving illegal access specific to the data or information contained in eHR of registered HCRs. Perpetrators of such cases should not be charged under section 161 of the Crimes Ordinance at the same time. Mr Alan LEONG and Ir Dr LO Wai-kwok have raised various concerns over the drafting of the English and Chinese versions of the clause. They are of the view that the drafting can be improved to make the clause more comprehensible and readable.

93. The Administration has explained that in determining which legal provisions should be invoked when pressing charges, the law enforcement agent would give due regard to the individual circumstances of each case. In general, the more specific provisions would be invoked. The Administration has further explained out that the wording of clause 41(6)(b) which follows that of section 161 of the Crimes Ordinance should be consistent with each other. It is intended

that consistency on the required criminal or dishonest intent should be maintained in providing for the new offence which is specifically directed at data or information in eHR (as opposed to "computer" generally) and criminalizing modification and impairment to the accessibility, reliability, security or processing in addition to "access" in relation to the data or information. The Administration is of the view that the current drafting of clause 41(6)(b) could serve its purpose.

94. Some members in general remain concerned about the circumstances under which a person would be charged with causing the access, modification or impairment with a dishonest intent to deceive under clauses 41(6)(b)(ii), (iii) and (iv). They have queried about the need for including dishonesty as an essential ingredient of the offences. The Administration has advised that the test for dishonesty under clause 41(6)(b) should be the same for the offences under section 161 of the Crimes Ordinance. A test of dishonesty which has been commonly applied in practice is the Ghosh test[7].

95. Members have requested the Food and Health Bureau ("FHB"), which is in charge of the Bill, to provide for reference of the Bills Committee information on the number of convicted cases involving charges of obtaining access to a computer with a dishonest intent to deceive, contrary to section 161(1)(b) of the Crimes Ordinance. The Bills Committee has also separately written to the Secretary for Justice to request the same set of information. Members note with disappointment the respective replies from the Security Bureau (through FHB) and the Department of Justice that no breakdown of the number of convicted cases under the different paragraphs of the relevant subsection of section 161(1) is available.

Offences relating to direct marketing

96. Clause 46 provides for offences relating to direct marketing in the context of the System. Dr KWOK Ka-ki has expressed concern about what would be regarded as causing "serious harm" under subclause (8)(c), which exempts the application of clauses subclauses (1) to (6) to the use or provision of data and information contained in the eHR (or a copy of the data and information) of another person, not for gain, for the purpose of offering, or advertising the availability, of social and healthcare services that, if not provided, would be likely to cause serious harm to the physical or mental health of the individual to whom the services are intended to be provided or any other individual.

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[7] According to the Administration, the leading authority on how to prove dishonesty is *R v Ghosh* [1982] QB 1053; 75 Cr App R 154, CA, which set out the Ghosh test. In brief, the Ghosh test is a two-stage test whereby the prosecution has to prove beyond reasonable doubt that the act is dishonest in the eyes of an ordinary person (i.e. an objective element) and that the defendant knew that he or she did was dishonest (i.e. a subjective element).

97. The Administration has advised that clause 46(8)(c) follows the wording in sections 35B(c) and 35I(1)(c) of the Privacy Ordinance which provide for offences relating to direct marketing using personal data in general. The term "serious harm" is not defined in the Privacy Ordinance. The interpretation of the term would therefore be based on its ordinary meaning. At the suggestion of the legal adviser to the Bills Committee, the Administration will move CSAs to amend clause 46(8) and (9) by replacing "healthcare services" with "health care services" to make it clear that the term has the same meaning as in sections 35B and 35I of the Privacy Ordinance.

Misuse of data and information contained in eHR in general

98. The Bill does not provide for any specific offence on general misuse of the data or information contained in the eHR of a registered HCR for purposes other than that for which the data and information is collected (except for the use or provision of data or information contained in the eHR (or a copy of the data and information) of another person for direct marketing as provided for under clause 46). The Administration has informed the Bills Committee that from the law enforcement or prosecution perspective, it might not be appropriate to impose an offence on misuse of eHR in general because misuse carries a broad meaning and there are different extents and various scenarios of misuse. It is also debatable whether all misuses should be penalized or even criminalized. The Bills Committee has discussed the Privacy Commissioner's suggestion that uses of data or information contained in eHR for purposes other than that for which the data and information is collected should be made an offence under the Bill.

99. Members have expressed diverse views on the issue. Some members are of the view that given the sensitive nature of health data, acts such as disclosure of the data and information of a registered HCR contained in the System on an online social networking platform and cyber-bullying, which fell outside the scope of use of eHR specified in the Bill[8], should be prohibited. Some other members, however, consider that any offence on misuse of the data or information contained in eHR should be for against specific acts as there are different extents and various scenarios of misuse of such data and information. Separately, the organizations and individuals which/who have responded to the Bills Committee's invitation for views on the issue have raised no particular views in this regard. Given its complexity, members agree not to pursue the issue further.

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[8] Clauses 26 to 29 of the Bill provide that the data and information contained in eHR may be used for improvement of healthcare provided (or to be provided) to a registered HCR, carrying out research and statistics related to public health or public safety, prevention or control of diseases and enhancement of disease surveillance or investigation, and as permitted by, or under, other law.

Complaints relating to the operation of the System

100. Members note that clause 48(1)(h) provides that the eHR Commissioner has the function to devise a mechanism for handling complaints relating to the operation of the System. Some members have suggested that to ensure clarity, the manner and form in which complaints are to be made and handled should be expressed stated. In particular, they are concerned about whether complaints lodged against the eHR Commissioner would be handled in a fair and impartial manner.

101. The Administration has advised that the mechanism would be devised with reference to existing relevant guidelines of the Administration, and suitably promulgated to stakeholders when available. While the eHR Commissioner's office would need to handle complaints, the major function of the office is to operate the System. The Administration, therefore, considers it inappropriate to stipulate detailed operational procedures of complaint handling in the Bill. The Administration has informed the Bills Committee that for complaints relating to suspected offences under the Bill, the Police would be the agency to investigate. For complaint relating to any suspected breaches of the Privacy Ordinance regarding the use of personal data in eHR, the Office of the Privacy Commissioner would be the lawful authority to follow up.

102. At the request of members, the Administration has provided for reference of the Bills Committee the draft framework for handling of complaints relating to operation of the System.

Power of the eHR Commissioner to require production of records or documents in certain circumstances

103. Clause 50 provides that the eHR Commissioner may in writing require a registered HCP to produce the record or document that is or may be relevant to an event, and that is in the HCP's possession if it appears to the eHR Commissioner that there are circumstances suggesting the happening of any of the following event: (a) the HCP contravenes a provision of the Ordinance (if enacted), a provision of a CoP issued by the eHR Commissioner, or a condition for the registration; (b) the HCP no longer provides healthcare at the service location to which the registration relates; (c) the HCP no longer complies with the requirements specified by the eHR Commissioner for connecting the HCP to the System, or the system requirements on data sharing specified by the eHR Commissioner; (d) the service or business nature of the HCP is no longer consistent with the purpose of the use of data and information is for improving the efficiency, quality continuity or integration of the healthcare provided, or to be provided, to HCR; and (e) the registration may impair the security or compromise the integrity of the System.

104. Mr Alan LEONG considers that the scope of record or document that the eHR Commissioner could require an HCP to produce in the context of subclause (1)(b) is too narrow as it covers record or document in that HCP's possession but not also record or document under that HCP's control. After consideration, the Administration has agreed to move CSAs to expand the scope to cover record or document "in the possession or under the control of the HCP". At the suggestion of the legal adviser to the Bills Committee, the Administration will move a further CSA to replace "registered HCP" with "prescribed HCP" in subclause (1) in order to also subject DH and HA to the requirement.

105. Some members take the view that given that the term "document" is not defined in the Bill, the Administration should consider whether it is sufficient for the Bill to rely on the definition of "document" in the Interpretation and General Clauses Ordinance for requiring the HCP concerned to produce, on request, documents in electronic or any other forms. The Administration, however, maintains that it is not necessary to do so, as the meaning of the term "document" as provided for in the above Ordinance (i.e. any publication and any matter written, expressed or described upon any substance by means of letters, characters, figures or marks, or by more than one of these means) and the revised drafting of the clause have sufficiently reflected its policy intent.

CoP

106. The Bill provides that the eHR Commissioner may issue a CoP indicating the manner in which the eHR Commissioner proposes to perform a function or exercise a power, or providing guidance on the operation of a provision of the legislation. The Administration has pointed out that the CoP so issued is an administrative instrument largely concerned with operational best practices and system technical requirements.

107. In response to members' enquiries about whether the eHR Commissioner would, by notice published in the Gazette, identity the CoP so issued, the Administration has advised that clause 51(2)(a) provides that the eHR Commissioner must publish the CoP in a manner appropriate to bringing it to the notice of persons affected by it. It does not preclude the use of gazette notice as one of the channels to publish the CoP. The Administration would also consult the relevant stakeholders before issuing or amending the CoP as appropriate.

108. Members are also concerned about whether there would be any legal implications if the provisions of a CoP are not complied with. The Administration has explained that unless an action of breach in itself constitutes an offence under the Bill or other law in Hong Kong, breach of any provision in CoP in itself would not directly impose on a person any civil or criminal liability as alternative

approaches or means that fulfill the underlying requirements on the level of care and standard of practice are acceptable. Following the guidelines in the CoP so issued, however, would help minimize the risk of breaching the legislation.

109. The Administration has informed the Bills Committee that subject to the usual evidential rules, a CoP issued by the eHR Commissioner, like any other public document, is admissible in legal proceedings. The legal adviser to the Bills Committee has enquired whether an express provision would be added to the Bill to make it clear that a failure to observe any provision of a CoP may be relied upon as tending to establish a particular matter in the proceedings or as taking such matter as provided. The Administration takes the view that the current drafting of clause 51 of the Bill is able to achieve its policy intent.

110. At the request of the Bills Committee, the Administration has provided a copy of the English version of the working draft of the CoP for using eHR for healthcare for reference of the Bills Committee. It has advised the Bills Committee that the document is prepared on a provisional basis and serves merely as an indication of the content of the eventual CoP in future, which could only be finalized after the passage of the Bill and further consultation with relevant stakeholders.

Liability of Government and public officers etc.

Criminal and civil liability of the Government and public officers

111. According to the Administration, its policy intent is that the Government and public officers would not be exempted from the criminal liability of the arising from the Bill. In response to members' enquiries on whether the limitation of liability by clause 57(1) is concerned with civil liability and/or criminal liability, the Administration has explained to the Bills Committee that the acts described in clause 57(1)(a) to (c)[9] are not a crime. The Government or a public officer will not be prosecuted merely because of such acts. Members note that the Administration will move CSAs to amend clause 57(1) to make it clear that the liability it seeks to limit is only civil liability.

Inspection of local eMR systems of prescribed HCPs

112. The Privacy Commissioner objects to the proposed arrangement under clause 57(2) that the eHR Commissioner is not obliged to inspect, or commit to inspect, the local eMR systems of prescribed HCPs to ascertain whether the

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[9] The acts include the use of the data or information contained in an eHR in accordance with the Ordinance (if enacted), the use of such data and information, subject to the approval of SFH, for research and statistics as provided for under clause 27, and approval of HCR or HCP's participation in the System.

ordinance (if enacted) is complied with; or whether any sharable data provided to the System is accurate.

113. The Administration has explained to the Bills Committee that the local eMR systems of the prescribed HCPs, which might contain a lot of other sensitive information not relevant to eHR sharing, are not part of the System and hence, outside the ambit of the eHR Commissioner. The Administration has also pointed out that while the eHR Commissioner, as a data user, will take reasonable steps to ensure that the use of the System would comply with the requirements under the Privacy Ordinance by usage of standardized codes and correct matching of person master index data with the health data to ensure the validity of input of data, he or she has no authority to vet nor the expertise and historical knowledge to assess the content accuracy of the data provided by the prescribed HCPs to the System. In addition, granting the eHR Commissioner with the power to inspect local eMR systems of HCPs is disproportionate to the need to do so. In addition, such inspection is also highly intrusive and might result in deterring HCPs from joining the System. According to the Administration, clause 57(2) is intended for preventing possible unmeritorious litigations against the Government.

114. Notwithstanding the Administration's explanation, members share the view of the Privacy Commissioner mainly on the ground that the proposed arrangement calls in question how the eHR Commissioner could exercise the supervisory and oversight role over the eHR effectively. It would also in effect reduce the Privacy Commissioner's enforcement power that might be invoked against the eHR Commissioner if there is non-compliance with the Privacy Ordinance. In particular, ensuring the integrity of eHR in the System is essentially the eHR Commissioner's obligation as a data user under data protection principles 2 and 4 of the Privacy Ordinance in relation to, among others, accuracy and security of personal data held by a data user.

115. After reconsideration, the Administration has agreed to drop the proposal from the Bill and will move CSAs to delete clause 57(2) of the Bill accordingly. The Bills Committee has written to organizations and individuals which/who have given views on the Bill to invite their views on the CSA and no objection was raised.

Protection of public officers etc.

116. While members generally agree that public officers should not be civilly liable for an act done or omitted to be done in exercising a power or performing a function under the Ordinance (if enacted) in good faith as provided for in clause 58 of the Bill, concern is raised as to whether persons appointed in writing by the eHR Commissioner under clause 48(3) to perform a function or exercise a power should be accorded similar protection. In particular, they are concerned about the

criteria upon which the eHR Commissioner would adopt in deciding whether a person should be appointed under clause 48(3) and conferred protection under clause 58. It is also not clear whether the protection is to be conferred on natural persons only, or also on legal persons such as a company.

117. The Administration has advised that the eHR Commissioner would need the expertise of HA to assist him or her in performing or exercising the functions or powers relating to the development, operation and maintenance of the System. To clarify the matter, the Administration has agreed to move CSAs to amend clause 58 of the Bill to the effect that the protection would be provided to an employee of HA, or an employee of a body corporate established by HA under section 5(n) of the Hospital Authority Ordinance (Cap. 113), appointed by the eHR Commissioner under clause 48(3). The Administration has informed the Bills Committee that the two principal subsidiaries of HA currently in operation are HACM Limited and eHR HK Limited. Both body corporates are companies limited by guarantee and incorporated in Hong Kong. There is no contractual relationship between either subsidiary and HA. The principal activity or function of HACM Limited is to steer the development and delivery of Chinese medicine services, whereas that of eHR HK Limited is to act as a custodian to hold, maintain and license the intellectual property rights and assets related to the eHR Programme.

118. The legal advisor to the Bills Committee has pointed out that the proposal to provide for protection of an employee of a body corporate established by HA from civil liability might constitute a departure from the existing legal policy as the protection under section 23 of the Hospital Authority Ordinance would apply to members of HA and members of committees only.

119. The Administration has pointed out that the protection under section 23 of the Hospital Authority Ordinance and that of the proposed CSAs to clause 58 are in respect of different contexts, based on different considerations. Its policy intent under the current legislative exercise is to confer the concerned protection against civil liability to experts from HA, irrespective of whether they are directly employed by HA or not, who are appointed by the eHR Commissioner in writing under clause 48(3) to assist him or her to perform particular functions and the concerned act or omission has to be "in good faith". The proposed arrangement is a matter of operational merits of individual cases, and not an issue of an overall legal policy as such. Provisions of such nature are also not uncommon in the law of Hong Kong.

<u>Appeals relating to registration for the System</u>

120. The Bill includes legislative amendments to the Administrative Appeals Board Ordinance (Cap. 442) to the effect that HCPs or HCRs who are aggrieved

by the eHR Commissioner's decision regarding their registration may appeal to the Administrative Appeals Board ("AAB").

121. In response to members' enquiry about the time required by AAB to process an appeal relating to the registration for the System, the Administration has advised that while specific requirements regarding the respective timeframe for submission of statements and written representations by the respondents and the appellants are provided for under the above Ordinance, AAB does not have specific performance pledge for processing an appeal which would depend on an array of factors, such as the number of applications received at around the same period and the time required due to additional requests or procedures made or caused by parties to the appeal.

Commencement of the Bill

122. Clause 1(2) of the Bill provides that the Ordinance (if enacted) will come into operation on a day to be appointed by SFH by notice published in the Gazette. The Administration has advised that among others, the proposed new definition of "sharing restriction request" and new clauses 3(e), 5(g), 5(h), 16A and 16B would come into operation at a later stage for reasons set out in paragraph 13 above.

Committee Stage amendments

123. Apart from the CSAs to be moved by the Administration as elaborated in paragraphs 13, 14, 28, 36, 46, 49, 51, 54, 59, 71, 83, 97, 104, 111, 115 and 117 above, the Administration will move some technical and textual amendments to the Bill. A full set of the draft CSAs to be moved by the Administration is in **Appendix III**. The Bills Committee does not object to these CSAs.

124. The Bills Committee will not propose any CSAs to the Bill.

Follow-up actions by the Administration

125. The Administration has made the following undertakings -

(a) intensive promotion, targeting on the residential care homes for the elderly, would be conducted when the System is in operation in order to encourage participation in the System by the elderly HCRs residing therein (paragraph 42);

(b) information on data sharing standards, interface specifications and interoperability requirements would continue to be provided to facilitate those private HCPs using non-government developed systems for connection to the System (paragraph 66);

(c) efforts would be made to promote HCRs' and HCPs' understanding of relevant precautionary steps and security measures for ensuring the security and integrity of the System through promulgation of guidelines and conducting publicity (paragraph 53);

(d) the safeguards under the Bill in relation to the use of identifiable data of a registered HCR for research or statistics purpose would be explained to the Hong Kong Alliance for Rare Diseases at a meeting (paragraph 72);

(e) a separate set of detailed guidelines for the eHR Research Board to consider an application for using the identifiable data of a registered HCR contained in the eHR for carrying out research, or preparing statistics, that are relevant to public health or public safety, would be formulated with reference to local and overseas practices (paragraph 70);

(f) further study, making reference to overseas experience, on additional access control for sensitive health data would be conducted along a positive direction in the first year of the second stage eHR Programme after the passage of the Bill, with a view to developing and implementing some form of new device or arrangement enabling additional choice for HCRs over the disclosure of their health data. Relevant stakeholders including the Steering Committee on Electronic Health Record Sharing, the Privacy Commissioner, medical professional bodies and patient groups, and the Panel would be consulted as appropriate on the proposed new feature upon the completion of the study (paragraph 12);

(g) a study on the setting up of a patient portal would be conducted in the first year of the stage two eHR Programme after the passage of the Bill, with a view to striking a proper balance between the convenience of HCRs' access and data security (paragraph 78);

(h) the requirements under section 33 of the Privacy Ordinance, which prohibits a data user to transfer any personal data to places outside Hong Kong except in specified circumstances, would be observed when the provision comes into operation (paragraph 60); and

(i) a review of the Ordinance (if enacted) would be conducted if the Privacy Ordinance is amended to the effect that unauthorized access of personal data without subsequent malicious act in general would be criminalized (paragraph 89).

Resumption of Second Reading debate on the Bill

126. The Bills Committee supports the resumption of the Second Reading debate on the Bill at the Council meeting of 8 July 2015, subject to the moving of the CSAs by the Administration.

Advice sought

127. Members are invited to note the deliberations of the Bills Committee.

Council Business Division 2
Legislative Council Secretariat
18 June 2015

Appendix I

Bills Committee on Electronic Health Record Sharing System Bill

Membership list

Chairman	Hon Charles Peter MOK, JP
Members	Hon Emily LAU Wai-hing, JP (since 15 May 2014) Prof Hon Joseph LEE Kok-long, SBS, JP, PhD, RN Hon Cyd HO Sau-lan, JP Dr Hon LEUNG Ka-lau Hon CHEUNG Kwok-che Hon Alan LEONG Kah-kit, SC Hon WU Chi-wai, MH Hon CHAN Han-pan, JP Hon Kenneth LEUNG (up to 19 May 2014) Hon Alice MAK Mei-kuen, JP Dr Hon KWOK Ka-ki Dr Hon Fernando CHEUNG Chiu-hung (since 13 May 2014) Dr Hon Helena WONG Pik-wan Dr Hon Elizabeth QUAT, JP Ir Dr Hon LO Wai-kwok, BBS, MH, JP (Total : 15 members)
Clerk	Ms Maisie LAM
Legal Adviser	Miss Carrie WONG

Bills Committee on Electronic Health Record Sharing System Bill

A. Organizations and individuals which/who have made oral representation to the Bills Committee

1. Arpmha
2. Civic Party
3. eHealth Consortium Limited
4. Hong Kong Academy of Medicine
5. Hong Kong Alliance of Patients' Organizations
6. Hong Kong Computer Society
7. Hong Kong Dental Association
8. Hong Kong Doctors Union
9. Hong Kong Private Hospitals Association
10. Hong Kong Registered Chinese Medicine Practitioners Association
11. Mobigator Technology Group
12. Office of the Privacy Commissioner for Personal Data
13. Senior Citizen Home Safety Association
14. Sin-Hua Herbalists' & Herb Dealers' Promotion Society Limited
15. System Aid Medical Services Limited
16. The Association of Licentiates of Medical Council of Hong Kong
17. The Hong Kong Medical Association
18. Professor John Bacon-Shone of the Social Sciences Research Centre, The University of Hong Kong

19. Dr Ashley CHENG Chi-kin

20. Ms June LUI Wing-mui

21. Mr NG Kwok-keung

B. Organizations and individuals which/who have provided written submissions only

1. Association of Hong Kong Nursing Staff

2. Hong Kong Information Technology Federation

3. Hong Kong Society of Medical Informatics

4. Regeneration Society

5. St. Teresa's Hospital

6. Young and App Services Limited

7. Professor FUNG Hong of The Jockey Club School of Public Health and Primary Care, The Chinese University of Hong Kong

8. Dr LAM Ching-choi, Chairman of the Working Group on Long Term Care Policy under the Elderly Commission cum Chief Executive Officer of Haven of Hope Christian Service

9. Dr TANG Shuk-ming

Electronic Health Record Sharing System Bill

Committee Stage

Amendments to be moved by the Secretary for Food and Health

Clause	Amendment Proposed
2(1)	In the definition of ***healthcare***, by deleting "in Hong Kong".
2(1)	In the definition of ***healthcare recipient***, by adding "in Hong Kong" after "be performed".
2(1)	In the definition of ***registered healthcare provider***, in paragraph (b), by deleting "bureau or".
2(1)	In the definition of ***registration***, in paragraph (c), by deleting "bureau or" (wherever appearing).
2(1)	In the Chinese text, in the definition of *使用*, by adding "、*用*" after "*使用*".
2(1)	In the Chinese text, in the definition of *醫護接受者*, by deleting everything after "指" and substituting "屬已經、正在或相當可能會在香港進行的醫護服務的對象的個人；".
2(1)	By deleting the definition of ***immediate family* member**.
2(1)	By adding in alphabetical order— "***family member*** (家人), in relation to a healthcare recipient, means an individual who is related to the recipient by blood, marriage, adoption or affinity; ***sharing restriction request*** (互通限制要求) means a request

made under section 16A(1)(a);".

3(2)(d) By deleting "an immediate family member of the healthcare recipient" and substituting "a family member of the healthcare recipient, or a person residing with the healthcare recipient,".

3(3)(d) By deleting the full stop and substituting a semicolon.

3(3) By adding—

"(e) being incapable of making a sharing restriction request at the time referred to in paragraph (g) or (h) of the definition of ***relevant time*** in subsection (5).".

3(4)(f) By deleting "an immediate family member of the healthcare recipient" and substituting "a family member of the healthcare recipient, or a person residing with the healthcare recipient,".

3(5) In the definition of ***relevant time***, in paragraph (f), by deleting the full stop and substituting a semicolon.

3(5) In the definition of ***relevant time***, by adding—

"(g) in relation to a sharing restriction request that is made under section 16A(1)(a), the time at which the request is made;

(h) in relation to a request to remove a restriction that is made under section 16A(1)(b), the time at which the request is made.".

3 In the Chinese text, by deleting "法庭" (wherever appearing) and substituting "法院".

10(1) By adding "for a period of not more than 28 days" before "if the".

10 By adding—

"(1A) Despite subsection (1), if the Commissioner considers it appropriate, the Commissioner may extend the period of suspension under that subsection for a further period

of not more than 28 days by notice in writing to the specified person.".

11(2) By deleting everything before "the Commissioner" and substituting—

"(2) Except for a cancellation under subsection (1)(e),".

11(2) By deleting paragraph (a).

11(2)(b) By deleting "takes" and substituting "is to take".

11 By adding—

"(2A) The specified person may, within 14 days after the date of the notice (or such longer period as the Commissioner may allow), make representations to the Commissioner to object to the cancellation in the manner specified in the notice.

(2B) The Commissioner must not cancel the registration unless—

(a) the specified person has not made any representations under subsection (2A); or

(b) the Commissioner has considered the representations and informed the specified person of the decision of cancellation.".

New By adding after Clause 16—

"**Division 3A—Sharing Restriction**

16A. Request for sharing restriction

(1) Despite anything contained in sections 12 and 16 and subject to subsections (2) and (3), a registered healthcare recipient, or a substitute decision maker of a registered healthcare recipient, may in relation to the health data of the healthcare recipient make—

(a) a request to restrict the scope of data sharing; or

(b) a request to remove a restriction on the scope of data sharing.

(2) If the healthcare recipient is a minor, the request must be made by a substitute decision maker of the healthcare recipient unless the Commissioner is satisfied that the recipient is capable of making the request.

(3) If the healthcare recipient is aged 16 or above and is incapable of making the request, the request must be made by a substitute decision maker of the healthcare recipient.

(4) A request made by a substitute decision maker of a registered healthcare recipient is made on behalf of and in the name of the recipient.

(5) In making a request, a substitute decision maker of a registered healthcare recipient must have regard to the best interests of the recipient in the circumstances.

(6) A request must be made to the Commissioner in the form and manner specified by the Commissioner.

(7) The Commissioner must notify the requestor in writing of the date on which the requested restriction, or the requested removal of restriction, takes effect.

16B. Commissioner to specify sharing restriction

(1) The Commissioner must specify the types of restriction in respect of which a person may make a request under section 16A(1).

(2) The Commissioner must make copies of a document setting out the specified types of restriction available to the public (in hard copy or electronic form).".

17(1) By adding "in Hong Kong" after "service location".

17(2) By adding "in Hong Kong" after "service location".

17(5)(e) By adding "or" after the semicolon.

17(5)(f) By deleting "; or" and substituting a full stop.

17(5) By deleting paragraph (g).

19(2) By adding "in Hong Kong" after "provides healthcare".

20 In the heading, by deleting "**bureaux and**".

20(1) By deleting "Government bureau or" and substituting "Government".

20(1) By deleting "operation of the bureau or department involves providing healthcare" and substituting "department provides a healthcare professional to perform healthcare for any healthcare recipient".

21(1) In the Chinese text, by deleting "其" and substituting "該提供者就其某登記".

22(1) By adding "for a period of not more than 28 days" before "if the".

22 By adding—

"(1A) Despite subsection (1), if the Commissioner considers it appropriate, the Commissioner may extend the period of suspension under that subsection for a further period of not more than 28 days by notice in writing to the healthcare provider.".

22(3) By deleting "bureau or".

23(2) By deleting everything before "Commissioner" and substituting—

"(2) The".

23(2) By deleting paragraph (a).

23(2)(b) By deleting “takes” and substituting “is to take”.

23 By adding—

“(2A) The healthcare provider may, within 14 days after the date of the notice (or such longer period as the Commissioner may allow), make representations to the Commissioner to object to the cancellation in the manner specified in the notice.

(2B) The Commissioner must not cancel the registration unless—

(a) the healthcare provider has not made any representations under subsection (2A); or

(b) the Commissioner has considered the representations and informed the healthcare provider of the decision of cancellation.”.

Part 3 In Division 4, in the heading, by deleting “**of Electronic Health Record Sharing System**” and substituting “**for Access to Electronic Health Record**”.

35 By deleting the clause.

New By adding in Part 3—

“**35A. Prescribed healthcare provider’s duties to restrict access to health data**

(1) This section applies if a prescribed healthcare provider is given a sharing consent by a registered healthcare recipient or a substitute decision maker of a registered healthcare recipient.

(2) The healthcare provider must take reasonable steps to ensure that—

(a) access to any health data of the healthcare recipient is restricted to a healthcare professional of the healthcare provider who may perform healthcare for the recipient; and

(b) the access is restricted to the health data that may be relevant for performing healthcare for the recipient.

(3) However, for complying with a data access request

or data correction request under Part 5 of the Privacy Ordinance, the healthcare provider is not to be treated as contravening the requirement under subsection (2) even if access to the health data is granted to a person other than the healthcare professional.".

37(2) By deleting paragraph (a).

38 By deleting the clause.

43 In the Chinese text, by deleting "揑" and substituting "揑".

46(8)(b) In the English text, by deleting "healthcare" and substituting "health care".

46(8)(c) In the English text, by deleting "healthcare" and substituting "health care".

46(9) In the definition of ***direct marketing***, by deleting the full stop and substituting a semicolon.

46(9) By adding in alphabetical order—

"***health care services*** (醫護服務) has the same meaning as in sections 35B and 35I of the Privacy Ordinance.".

50(1) By deleting "registered" and substituting "prescribed".

50(1)(b) By deleting "healthcare provider's possession" and substituting "possession or under the control of the healthcare provider".

53 By adding—

"(2A) A person may be appointed as a non-ex officio member only if the person is, in the Secretary's opinion, a person—

(a) having expertise or experience in healthcare, privacy protection, statistics, research, law or

information technology;

(b) representing the interests of healthcare recipients; or

(c) having other experience that would render the person suitable for the appointment.".

53(3) By deleting "the period" and substituting "a term of not exceeding 5 years".

53 By adding—

"(3A) A non-ex officio member is eligible for reappointment on the expiry of a term.".

53 By adding—

"(5A) The Secretary may terminate the office of a non-ex officio member if satisfied that—

(a) the member has ceased to be of the capacity because of which he or she was appointed; or

(b) the member is otherwise unable or unfit to perform the functions of a member of the Board.

(5B) Every appointment or termination under this section is to be notified in the Gazette.".

57(1) By deleting "is not liable" and substituting "does not incur any civil liability".

57 By deleting subclause (2).

58(3) By deleting paragraph (b) and substituting—

"(b) an employee of the Hospital Authority, or an employee of a body corporate established by the Hospital Authority under section 5(n) of the Hospital Authority Ordinance (Cap. 113), appointed by the Commissioner under section 48(3)."