WONCA Policy Statement on eHealth 2016

1. The primary aims of Health Information Systems (HIS) should be to empower patients and health professionals by
   - supporting patients' self-management, shared decision-making, easy communication with the primary care provider, and data entry into personal health records which patients can share with their care providers;
   - supporting professionals in delivering care that has high quality and is safe.

   Health Information Systems should also provide patients with reliable information on health, disease and relevant care.

2. Each patient should have one record containing essential coded data including, as a minimum: problems, medication list, test and examination results, procedures and management plans; across all levels of health care and social care when needed, in order to promote continuity, patient-centeredness, team work, integrated care, and care coordination by the family doctor. Patients should have access to their records and control over who can access their data.

3. Family doctors and patients should have the right to use information technology tools that are tailored to their needs. This can be accomplished by making the data interoperable and shareable by different tools, including mobile applications.

4. Health Information Systems should enable and facilitate the coding of high-quality data in a standardized manner so as to allow processing by computer, clinical decision support, personalised medicine, automation of tasks, and patient-oriented service provision.

5. Health Information Systems should enable the family doctor to analyse the health data of the whole population for which he or she is responsible, in order to identify care gaps in people who would benefit from health care interventions, and to serve the people with the greatest health care needs.

6. Health Information Systems developers should engage family doctors and patients in the development of tools that support the care of people with multiple morbidities and polypharmacy; facilitate care coordination and promote evidence-based practice, while preventing fragmentation of care, overdiagnosis, overtreatment and medicalization.

7. Health Information Systems should help primary care providers to learn from every patient, every intervention and its outcome. Health Information Systems should enable the capture of coded data from electronic health records and personal health records in a standardised manner, and the deposit of such coded data into repositories controlled by the primary care unit that has generated the data, for use at the unit, and for sharing standardised data reports for quality improvement and benchmarking.

8. Health Information Systems should enable the sharing of anonymised or encrypted data through safely maintained and publicly controlled repositories for the generation of new knowledge via research and big data analysis. The primary care units should make their participation in data sharing known to patients, and patients should be granted the choice to opt out from sharing their data or to pose restrictions on the ways in which their shared data can be used.

9. Governments, in close collaboration with health care professionals, should endorse and implement eHealth strategies and infrastructures that include standardisation and interoperability, and develop their regulations to facilitate the use of data for research, development and innovation in a secure and safe manner, so as to guarantee the rights of the individual.

10. Governments should ensure access for professionals and patients to the best available health information systems and continuously updated clinical knowledge in primary care, education and training in health literacy and in the use of IT tools. Governments should also ensure the availability of aggregated data for decision making and management.

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