

ICS 35.240.80
CCS C 07



**NATIONAL STANDARD OF THE
PEOPLE'S REPUBLIC OF CHINA**

GB/T 24466-2026

Replacing GB/T 24466-2009

**Health informatics - Requirements for an electronic health
record architecture**

健康信息学 电子健康记录体系架构要求
(English Translation)

Issued on: July 2, 2026

Implemented on: November 1, 2026

Issued by: State Administration for Market Regulation

Table of Contents

Preface
Introduction
1 Scope
2 Normative References
3 Terms and Definitions
4 Abbreviations 3.
5 EHR Business Objectives
5.1 Overview
5.3 Clinical Practice Goals
5.4 Citizen Participation Objectives
6 EHRA Requirements
6.1 Overview
6.2 Requirements for the Representation of Clinical Information
6.3 Communication and Interoperability Requirements
6.4 Ethical and Legal Requirements
6.5 Fair Information Principle
References

Foreword

This document complies with the provisions of GB/T 1.1-2020 "Standardization Work Guidelines Part 1: Structure and Drafting Rules of Standardization Documents".

Drafting.

This document supersedes GB/T 24466-2009 "Requirements for Electronic Health Record System Architecture in Health Informatics" and is consistent with GB/T 24466-Compared to 2009, aside from structural adjustments and editorial changes, the main technical changes are as follows.

a) Added the terms "authorization", "availability", "healthcare plan", "clinical information", "clinical process", "electronic health record", and "electronic health".

"Health Record Architecture", "Electronic Health Record System", "Entries", "Healthcare Professionals", "Healthcare Providers", "Information Model", "Complete" "Sex", "Knowledge Model", "Organization", "Persistence", "Strategy", "Role", "Service", "Workflow" and their

definitions (see 3.4~3.12).

(3.14, 3.15~3.23, 3.25)

b) The definition of the term "electronic health record" has been changed (see 3.9, 3.17 of the 2009 edition);

"Employees", "Consumers (related to healthcare services)", "Data Integration", "Data Verification", "EHR Extraction", "EHR System", "EHR" "Transaction", "Face-to-face consultation", "(Nursing) segment", "(EHR-related) event", "Framework", "Healthcare record", "Non-repudiation", "Patient" "Personnel", "Problem-oriented (including issues and conditions)", "Record items", "Role", "Second-level application (of healthcare records)", "(Information) security" "Completeness," "(process) status," "treatment and prevention measures," and their definitions (see 3.1-3.3, 3.5, 3.12, 3.14-3.16 of the 2009 edition).

(3.19~3.25, 3.27, 3.29, 3.30, 3.32~3.34, 3.36, 3.37, 3.39, 3.41)

d) The detailed classification description of the EHR architecture requirements framework has been removed (see Chapter 4 of the 2009 edition);

e) Added content on "Abbreviations" and "Electronic Health Record Business Objectives" (see Chapters 4 and 5);

f) Change "STR1-structure" to "Clinical information representation requirements," including the types, structure, and contextual representation of health record entries.

Record internal links, representation of data values, EHRA data retrieval and views, and representation and support of clinical processes and workflows (see...).

6.2 (5.1 in the 2009 edition)

g) Integrate the "PRO2-Process" into "Representation and Support of Clinical Processes and Workflows," and add "Healthcare Plans" and "Medical Orders." Detailed terms such as "single and service support" are provided (see 6.2.7, 5.2 of the 2009 version);

h) The "Communication and Interoperability Requirements" section has been revised, and content related to interoperability standard support and audit trails has been added (see 6.3, 2009).

Version 5.3);

i) The "fair information principle" has been added, including requirements on responsibility, purpose identification, consent, and limitations on collection, use, disclosure, and retention (see...).

This document is modified to adopt ISO 18308:2011 "Health Informatics - Requirements for the Architecture of Electronic Health Records".

Compared with ISO 18308:2011, this document has undergone the following structural

adjustments.

---Terms 3.2 to 3.25 correspond to terms 3.3 to 3.9, 3.20 to 3.22, 3.24, 3.26, and 3.31 in ISO 18308:2011, respectively.

---A new chapter on "Normative References" has been added;

---5.1.2 and 6.1.2 correspond to Chapter 2 of ISO 18308:2011;

--- An overview section (6.1) has been added; subsequent chapter numbers will follow the same order.

The technical differences between this document and ISO 18308:2011, and the reasons therefor, are as follows.

--- Twenty-three terms and their definitions, including "certification," "code meaning," and "code value," have been removed from ISO 18308:2011 to comply with...

Requirements of GB/T 1.1-2020 and GB/T 20001.1-2024.

The following editorial changes have been made to this document.

---In order to comply with the requirements of GB/T 1.1-2020, the source documents of obsolete terms in the terminology have been replaced and the source of some terms has been changed.

Please note that some content in this document may involve patents. The issuing organization of this document assumes no responsibility for identifying patents.

This document was proposed and is under the jurisdiction of the China National Institute of Standardization.

Introduction

Standardization in the healthcare field is crucial for supporting the implementation of the "Healthy China" strategy, promoting the construction of a tiered healthcare system, and ensuring the quality of medical services.

The core foundation of security. Electronic health records, as the core carrier for recording an individual's health and healthcare information throughout their entire lifespan, have a structure that...

Scientific rigor and standardization directly determine the level of interoperability of health information, the effectiveness of clinical applications, and the ability to ensure data security; they are essential for achieving cross-machine communication.

It is a key support for the collaborative development of medical services across regions and levels.

Currently, my country's electronic health record construction has entered a stage of

large-scale promotion and in-depth application, but it still faces challenges such as inconsistent architecture leading to information silos.

Insufficient interoperability, an imperfect data security and privacy protection system, and insufficient flexibility in adapting to diverse scenarios such as tiered medical services and home care.

The problem. Meanwhile, with the rapid development of "Internet healthcare" and smart healthcare, electronic health records and clinical data centers (CDRs) are emerging.

The need for collaboration between Personal Health Records (PHRs) and the National Health Information Platform is becoming increasingly urgent, necessitating the standardization of their architecture.

Seeking solutions to industry pain points such as information silos and data misuse.

This document was prepared in response to the practical needs of high-quality development of healthcare information technology in my country, in order to support full life-cycle health management.

With integrated healthcare services and public health emergency response as core objectives, this document establishes unified requirements for the electronic health record architecture.

Based on ISO 18308:2011, and fully combined with my country's hierarchical medical system policy, legal requirements for data security and privacy protection, and national...

The technical specifications for interconnection and interoperability of the national health information platform will achieve a deep integration of international standards and domestic conditions.

This document focuses on the core elements of electronic health record architecture, covering clinical information representation, communication and interoperability, ethics and law, and equity.

The four dimensions of the information principle clarify the flexibility, security, and scalability that the architecture should possess, and focus on addressing cross-system data exchange and privacy.

It addresses key issues such as refined management. Its release and implementation will facilitate the sharing of health information across different medical institutions, regions, and scenarios.

Ultimately, this will promote improvements in the efficiency, quality, and cost control of healthcare services, effectively safeguarding the health rights of the people.

Health Informatics Electronic Health Record System Architecture Requirements