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Online prescribing services: sharing medicines-related information to My Health Record by default

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The Australian Medical Association (AMA) welcomes the opportunity to respond to the consultation on requiring online prescribing services to share medicines-related information to My Health Record (MHR) by default.

The AMA supports the intent of this reform. Safe prescribing depends on doctors and other treating practitioners having timely access to accurate, clinically meaningful medicines information. This is especially important when patients receive care from multiple providers, including direct-to-consumer (DTC) online prescribing services that may sit outside a patient's usual care team.

This reform is necessary because the health system is now dealing with prescribing models that were not contemplated when many regulatory, clinical governance and information-sharing arrangements were designed. DTC and single-issue online prescribing services can offer convenience and access, but they may also fragment care, weaken communication with a patient's usual general practitioner (GP), and leave other treating practitioners without visibility of medicines that affect clinical decision-making. Continuity of care with a patient's chosen GP is associated with lower mortality, reduced use of out-of-hours care, and fewer acute hospital admissions.

The AMA has previously raised concerns about online models providing prescriptions without meaningful consultation, lacking clear referral pathways, or failing to maintain an adequate feedback loop with GPs and other treating practitioners. These risks are especially evident in, for example, medicinal cannabis prescribing, where rapid growth in DTC telehealth models has exposed gaps in clinical governance, regulatory oversight, information sharing, and patient safety.

The AMA supports requiring online prescribing services to share medicines-related information to MHR by default as a minimum safety requirement. However, information sharing is not a complete answer to unsafe online prescribing. It must sit within a broader framework of professional standards, clinical governance, software interoperability, privacy safeguards and meaningful compliance.

The AMA has welcomed the National Medicines Record as a step towards reducing fragmented care and medicine-related harm. This reform should support this objective by ensuring medicines information is interoperable, computable, clinician-curated, de-duplicated and embedded into practice and hospital software, rather than creating another disconnected portal or compliance exercise. The central test should be whether it helps doctors and other treating practitioners make safer decisions at the point of care.

Sharing medicines information to support continuity of care

The AMA supports requiring online prescribing services to share medicines-related information to MHR by default. This is a practical patient safety measure and a necessary step towards a more complete medicines record. However, information sharing should not be treated as a substitute for coordinated care. The AMA recognises telehealth and online prescribing can improve access where they are clinically appropriate and properly integrated with the patient's broader care, particularly for patients who face barriers to in-person care.

Some care models are designed around episodic, transactional prescribing with limited connection to the patient's usual GP or specialist. Services that provide re-prescriptions outside usual GP care can reduce opportunities for preventative care, screening, risk modification and broader clinical review. The AMA has also raised concerns about single-issue online telehealth providers, including services that prescribe without meaningful consultation or rely on text, email or online questionnaires rather than a face-to-face, video or telephone consultation. The sector has emphasised this point in relation to the prescribing of medicinal cannabis, where many DTC, single-issue telehealth models pose safety risks and may perpetuate poor health outcomes.

This reform must be framed as part of a broader clinical governance response to increasingly fragmented prescribing. Uploading a prescription to MHR may improve visibility, but it does not discharge a prescriber's professional obligation to undertake an appropriate assessment, consider the patient's medicines history, communicate where clinically necessary with the patient's usual care team, and provide appropriate follow-up.

This point is particularly important for asynchronous or questionnaire-based prescribing. The final rules and guidance must clarify that sharing medicines information is one component of safe prescribing. It must sit alongside professional obligations for appropriate assessment, clinical judgement, documentation, follow-up and coordination with the patient's usual treating team.

Direct-to-consumer and high-risk prescribing must be clearly captured

The AMA strongly supports applying the requirements to DTC and predominantly online prescribing services, including services operating outside the Medicare Benefits Schedule (MBS). Many services of the greatest concern are privately funded, highly marketed, and structured outside established referral or ongoing care arrangements. Compliance arrangements must address this regulatory gap and apply effectively to non-MBS services, vertically integrated services, and commercial platforms combining prescribing, product supply and dispensing arrangements.

We understand the proposed scope is directed at services operating solely or predominantly through telehealth or digital platforms, focussing upon prescribing which occurs outside an established therapeutic relationship involving face-to-face care. The final rules should be tightly defined to avoid inadvertently capturing ordinary telehealth provided by GPs or non-GP specialists as part of established, ongoing care. Telehealth is now a routine and clinically valuable part of medical practice. The policy focus should be on fragmented, transactional and predominantly online prescribing models, not on the modality of consultation alone.

The AMA is concerned boundaries around "hybrid" services could be exploited. A service should not avoid information-sharing obligations by offering limited or nominal face-to-face access while operating in substance as a predominantly online prescribing business. The rules need to look at the

nature of the model, the pathway through which patients receive prescriptions, and the degree to which prescribing occurs outside an established therapeutic relationship.

High-risk medicines should be prioritised, and the AMA does not support excluding them from sharing requirements. Medicines with dependency, impairment, interaction or misuse risks are the medicines for which visibility matters most. Sensitivity is a reason to design appropriate safeguards and ensure clinically important information is visible to treating practitioners involved in the patient's care. This includes opioids, benzodiazepines, psychostimulants, medicinal cannabis and other medicines where fragmented information can lead to serious harm.

For high-risk medicines, core prescription and dispensing information may not be enough. The record should include sufficient structured clinical context to support future decision-making. This should include the indication, therapeutic rationale, intended duration, review arrangements, relevant monitoring requirements, and cessation or exit planning where appropriate. This is particularly important where the online prescriber is unlikely to have an ongoing role in the patient's care.

Information shared must be clinically useful at the point of care

Medicines information will only improve patient safety if it is useful to doctors and other treating practitioners in real clinical settings. The AMA maintains a useful medicines record should be interoperable, computable, clinician-curated, and embedded into GP and hospital software. It supports care at the point of decision and does not create another disconnected digital task.

Mandatory upload will serve little purpose unless access is low friction, reliable and complete. MHR must move beyond the "shoebox of PDFs" model. Prescribing and dispensing information should be available through usable interfaces, including appropriate application programming interfaces or equivalent integration mechanisms, so practice and hospital software can pull collated medication data into the systems clinicians already use. A separate MHR-informed medication list in another browser, with another login and another authentication process, would not represent a meaningful gain for prescribers, patients or the community.

The AMA supports nationally consistent terminology, interoperability and software conformance requirements so medicines information can be safely matched and interpreted across care settings. The system must allow clinicians to understand who prescribed the medicine, whether it was dispensed, whether the prescription remains current, and whether the record reflects active treatment or a historical prescribing event. Without this clarity, medicines information may create confusion or false reassurance rather than support safer care.

The government should be clear about what constitutes reasonable use of MHR medicines information in clinical practice. Doctors should not be exposed to unclear professional or medico-legal expectations where medicines information is incomplete, hidden by consumer controls, duplicated, poorly displayed, or not integrated into their local software. If clinicians are expected to check and rely on medicines information before prescribing, the system must be reliable, clinically usable, and supported by clear guidance about reasonable steps in real-world practice.

There are already multiple sources of prescribing and dispensing information doctors may need to consult, including PBS records in MHR, and state-based real-time prescription monitoring systems. Where these systems do not integrate directly with prescribing software, reconciliation becomes manual work requiring re-entry of new or changed medicines and management of duplicate

prescribing and dispensing events. This reform should therefore be designed as an early stage of a consolidated, de-duplicated and clinically usable National Medicines Record, not as another partial dataset.

Privacy safeguards must not create unsafe blind spots

The AMA supports maintaining consumer control over MHR and ensuring patients have clear, accessible information about how their medicines information is shared and managed. Privacy is especially important where medicines may reveal sensitive or stigmatised conditions.

However, privacy protections should be designed to preserve clinical safety. Broad medicine-category exemptions would risk undermining the purpose of reform. In common with all medicines, those deemed sensitive may remain clinically important because they have interaction, dependency, impairment, pregnancy, mental health, perioperative or safety implications. If these medicines are routinely absent from the record, doctors and other treating practitioners may be left with a medicines history that appears complete but is not and may ultimately lose faith in using the record.

Incomplete medical records can create false reassurance. A treating doctor may reasonably rely on the available medicines history when assessing adverse effects, prescribing another medicine, preparing a patient for surgery, managing acute deterioration or coordinating care across settings. If high-risk or sensitive medicines are invisible by design, the system may fail precisely when it is most needed. A partial medicines record cannot properly support safe prescribing.

MHR includes an emergency access function that can override access controls in limited circumstances, but it is not a general workaround for incomplete medicines information. It is available only where statutory requirements are met, is subject to audit and privacy obligations, and does not allow access to removed information or personal health notes. The existence of emergency access should therefore not be used to justify broad privacy settings or medicine-category exclusions that routinely leave clinically important medicines information absent from the record.

Maintaining consumer controls and applying proportionate safeguards should allow patients to understand what is shared, restrict access where appropriate, and discuss concerns with their treating practitioner. However, default settings also need to support safe care by ensuring clinically important medicines information is available for ordinary clinical decision-making unless a recognised exception applies. Privacy design should be informed by both patient autonomy and clinical risk. Regulatory settings must consider whether information is sensitive, but also what harm may occur if it is unavailable in routine care where a doctor has a legitimate clinical need but cannot use emergency access. That balance is essential if MHR is to support both patient autonomy and patient safety.

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