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Online Prescribing Services Sharing Medicines-related Information to My Health Record by Default Consultation

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About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,100 physicians and 8,900 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties. Beyond the drive for medical excellence, the RACP is committed to developing health policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

RACP's position

The RACP welcomes the opportunity to respond to the Department of Health, Disability and Ageing consultation *Online prescribing services: Sharing medicines-related information to My Health Record (MHR) by Default*.

The RACP supports Sharing by Default as a necessary step toward safer, more integrated digital health systems for patients accessing online prescribing services. However, this reform will only achieve its objectives if it is implemented with clear scope, appropriate clinical safeguards, and system capability that reflects the realities of complex care.

For the scheduled expansion of Sharing by Default to online prescribers, we recommend that the Department should:

- Clarify the application of Sharing by Default requirements for 'online prescribers' to physicians and trainees providing MBS services exclusively via video and telephone consultations.
- Require mandatory medicines information fields for online prescribing services. This should include current and ceased medicines, prescribing and dispensing episodes, allergies and adverse drug reactions, medication changes and reasons, medication reconciliation records, prescribing practitioner identification, and document provenance.
- Ensure My Health Record supports interoperable, structured medicines information (including AMT-coded data) that integrates with physician workflows and community practice software, rather than relying on free text and PDF.
- Require online prescribers to notify a patient's regular prescriber of all Schedule 8 and Schedule 4D prescriptions, in addition to recording them in My Health Record.
- Require online prescribers to notify treating physicians of prescriptions or treatment changes for patients receiving specialist-led care, particularly those with complex care needs, where this is identifiable from My Health Record or the patient history.
- Not exempt any direct-to-consumer or similar online health service models from Sharing by Default requirements.
- Clearly communicate privacy law obligations to online prescribing services and establish a transparent liability framework for practitioners relying on My Health Record when prescribing.
- Improve My Health Record usability, integration and uptake through minimum usability standards for certified portals, targeted education on medicines information limitations, and measures addressing technical, workflow, training and incentive barriers to physician adoption.

These elements would build confidence in record reliability, integrate physician information flows with online prescribing information and maximise the value of the Sharing by Default framework, delivering major safety gains to patients.

Key requirement: clarity on physician MBS virtual care services

The definition of 'online prescribers' for the scheduled expansion of Sharing by Default later in 2026 provides little clarity for physicians and trainees delivering MBS services using mixed digital modalities across a continuum of patient care, for whom eligibility constitutes a grey area.

It centres as the key example for Sharing by Default 'direct to consumer care' models and excludes services which combine in-person and online care. The effect is an inference that the requirements are for services that self-identify or behave as online prescribers, leaving open impact for physicians and trainees who use video and telephone modalities in lieu of in-person consultation for specific patients. As physicians delivering MBS complex care items may use video for an initial consultation and telephone for subsequent consultations in providing care to a patient in a 12-month referral cycle, our questions for the Department include:

- Are the Sharing by Default requirements strictly applicable to self-designated ‘online prescribers’, or do they also apply to physicians using video or telephone only to deliver an MBS service for specific patients of their case list?
- Would Sharing by Default requirements apply only to patients wholly accessing virtual modalities of the physician’s entire patient case mix, or to a physician’s entire patient mix when they meet or exceed certain numerical or percentage thresholds for online delivery?
- What consideration has been given to the impost of patient case mix sorting, record administration and assurance checks and what transitional support would be facilitated to assure ongoing delivery of care is balanced with additional record administrative requirements prior to phase in?

Operational clarity from the Department on these matters and ongoing engagement on expected rollout sequence would reduce implementation risk, system gaps and delays to overall rollout.

Responses to specific questions

What do you think matters most to people who use online prescribing services and what medicines information should be required to be shared to My Health Record to support safer and more coordinated care?

The consultation background paper appropriately identifies transitions of care between practitioners and services as the stage which presents the greatest risk for medication errors in the care continuum for patients. To support more coordinated care during transitions for the complex patients of physicians who use online prescribing services, the information shared to My Health Record should encompass:

- current and ceased medicines
- prescribing and dispensing episodes
- documented allergies and adverse drug reactions
- medication changes and the reasons for those changes
- medication reconciliation records
- and clear identification of the prescribing practitioner and document provenance.

Sharing by Default will be optimised by inclusion of these input fields, reducing oversight, duplication risks and avoidable delays or disruptions to care for physicians and trainees working with a patient and online prescribers.

Equally important is how medicines information is presented. Information should be available in structured, interoperable formats rather than in static PDF, enabling incorporation into clinical decision support and prescribing digital workflows. As patients increasingly access online prescribing services, physicians and trainees urgently require medicines information to be available and transferable to the digital systems they routinely use to support safe clinical decision-making at the point of care.

The obligation to refer to My Health Record prior to prescribing should accompany the requirement to share records, particularly as concerns online prescribing services which, having no or limited background with a patient, may make decisions with heightened clinical risk.

Should different requirements such as stronger safeguards apply for higher risk medicines (for example opioid pain or stimulant medication) and are there medicines that should be exempt or treated differently due to their potential sensitivity or risk?

Certain medicines including Schedule 8 and Schedule 4D medicines for potential abuse, misuse, diversion and addiction should be subject to stronger safeguards in online prescribing services. For these medicines it would be wholly appropriate for an online prescriber to directly inform regular prescribers of such a prescription via email or phone in addition to transcription in My Health Record.

In keeping with good practice however, it is not only a medicine type but the clinical complexity of specific patient priority groups which heightens prescribing risk. We suggest that for complex patients

consulting physicians there is need for timely onward communication of online prescriptions and changes to prescriptions to regular prescribers for many Schedule 4 medicines, given high and hazardous potential to interfere with complex treatment plans and foreseeable consequences for the health system. This would apply to a range of priority groups, including patients with substance use disorders, chronic pain conditions, palliative care needs, complex multimorbidity, neurodevelopmental conditions, paediatric patients, and patients with acute undifferentiated presentations and elderly patients.

These patient groups are more likely to suffer from medicines information gaps in online prescribing settings and these groups should be a specific focus of the implementation design process.

Please refer to our recent submission to the Pharmacy Board of Australia consultation on endorsement for scheduled medicines for pharmacists for a more thorough overview of medicines requiring extreme caution in prescription, dosing and titration and the priority groups to which these cautions apply.

Are the requirements for online prescribing services to share medicines-related information to My Health Record clear and are there any online prescribing services that should be excluded from the new requirements to share to My Health Record, and if so, why?

The information provided is clear, notwithstanding the status of physicians providing virtual MBS services to specific patients across care continuum for the next stage of Sharing by Default, which needs clarification.

There are no online prescribing services which should be excluded and a special focus should be on ensuring the inclusion of 'direct to consumer models' which require no prior engagement with a patient, because:

- These services have limited capacity to perform the thorough medicines history review which underpins safe physician prescribing inclusive of primary care referral information, and false confidence is possible; it is crucial that any prescriptions made by these services and other online prescribing services be made visible to treating physicians via the Sharing by Default framework.
- Prescribing is a person-centred, iterative process, not a single point in time occurrence. It involves monitoring, assessment and risk management. Physicians and trainees must be able to understand the clinical reasoning of online prescribers at the point an online consultation was undertaken and incorporate that information into clinical workflows.
- Exclusion from Sharing by Default would limit checks and balances over online prescribing businesses, where there may be financial interests in a medicine being prescribed or incentives to prescribe.

How should people's privacy and individual choice be balanced with safe and coordinated care when medicines prescribed by online prescribing services are shared to My Health Record by default and what should Government consider in supporting healthcare providers to check medicines information in My Health Record, before prescribing or dispensing?

Safe and coordinated care depends on medicines information being available to the broader treating team, noting that fragmentation from online prescribing increases patient risk.

Sharing by Default should preserve appropriate privacy protections for patients with sensitive diagnoses while ensuring that privacy settings do not inadvertently omit key medicines information that is necessary in the delivery of safe care. Any medicines prescribed through online prescribing services should therefore be visible within My Health Record to support informed clinical decision-making.

In a recent submission to Medicare, we reported that current medications and dosages are one of the most frequently missing items in referral information for the patients of physicians. The proposed opt-out architecture would constrain the completeness of medicines information available to treating physicians and present a practical workflow issue. Government should however also ensure privacy law obligations are clearly communicated to online prescribing services as a balancing measure.

In supporting prescribing practitioners to routinely refer to My Health Record before prescribing, practitioners would benefit from a liability framework to improve the understanding of their professional risks in relying upon information contained in a record. In situations where an online prescribing service has failed to comply with a mandatory sharing requirement, the liability position of a treating physician or trainee who relied on an apparently complete My Health Record needs further explanation and education.

To lift prescriber engagement with My Health Record, we have called for minimum usability baselines for certified My Health Record portals, including medication reconciliation views, clear allergy and intolerance visibility, and transparent document provenance. Improved education and awareness for prescribers on products precluded from My Health Record, including complementary or alternative products, supplements, substitute regimens, and off-label medicines, is also needed so at the point of care practitioners relying on this information can understand limitations to forming a thorough view of all treatments taken by a patient.

The Government must also consider how the information can be seamlessly integrated into clinical workflows and the support needed to make this operational. When local health services (private physician practices, community clinics, rural hospitals, small hospitals) cannot access or integrate MHR data effectively, the information chain is broken and the benefits of mandatory sharing will not be realised. Physician engagement with My Health Record can be limited due to several enduring barriers we highlighted in our 2025 submission to the Review of My Health Record legislative instruments:

- **Low incentive structures**: unlike general practitioners, specialists have not been offered targeted incentive payments to support MHR adoption.
- **Technical and workflow challenges**: many specialist practices face integration issues with clinical software, lack of templates for specialist letters, and administrative burdens associated with MHR setup and use.
- **Limited awareness and training**: there is insufficient tailored education and support for specialists, particularly in private and rural settings.
- **Privacy and access concerns**: ambiguities around access controls and patient consent have led to hesitancy among clinicians.

What impacts or challenges should government consider before implementing this reform?

Technical gaps preventing the wide range of online prescribers from participating in Sharing by Default by the launch time are a real and significant threat, presenting a unique challenge for physicians and trainees needing to receive contemporaneous updates from online prescribers and contribute to administrative burdens for patients accessing these providers. The Government must consider the likelihood of patchiness in the roll out and the need for technical support and incentives to encourage onboarding and reduce administrative burden.

Physicians and trainees work in community, secondary, tertiary, and clinical consultancy services across public and private sectors. MHR and related modules are vitally important to informing the clinical decisions of physicians and trainees in all these services. Robust mechanisms are needed to link MHR record information to the range of software systems used. The clinical implications of online prescribing are critical to physicians and trainees effectively caring for patients across all work and service settings.

The format of information uploaded into My Health Record must also align with the workflow systems used in physician practice to maximise the utility of the data in care. Moving beyond PDF and free text entries toward AMT-coded entries is a key example of such alignment.

Getting the online prescribing services sharing medicines-related information to My Health Record by default right will be critical to achieving and maintaining optimal levels of care for the patient and ensuring the effective and efficient operation of MHR across the health systems. The RACP is looking forward to ongoing engagement in these important conversations.

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