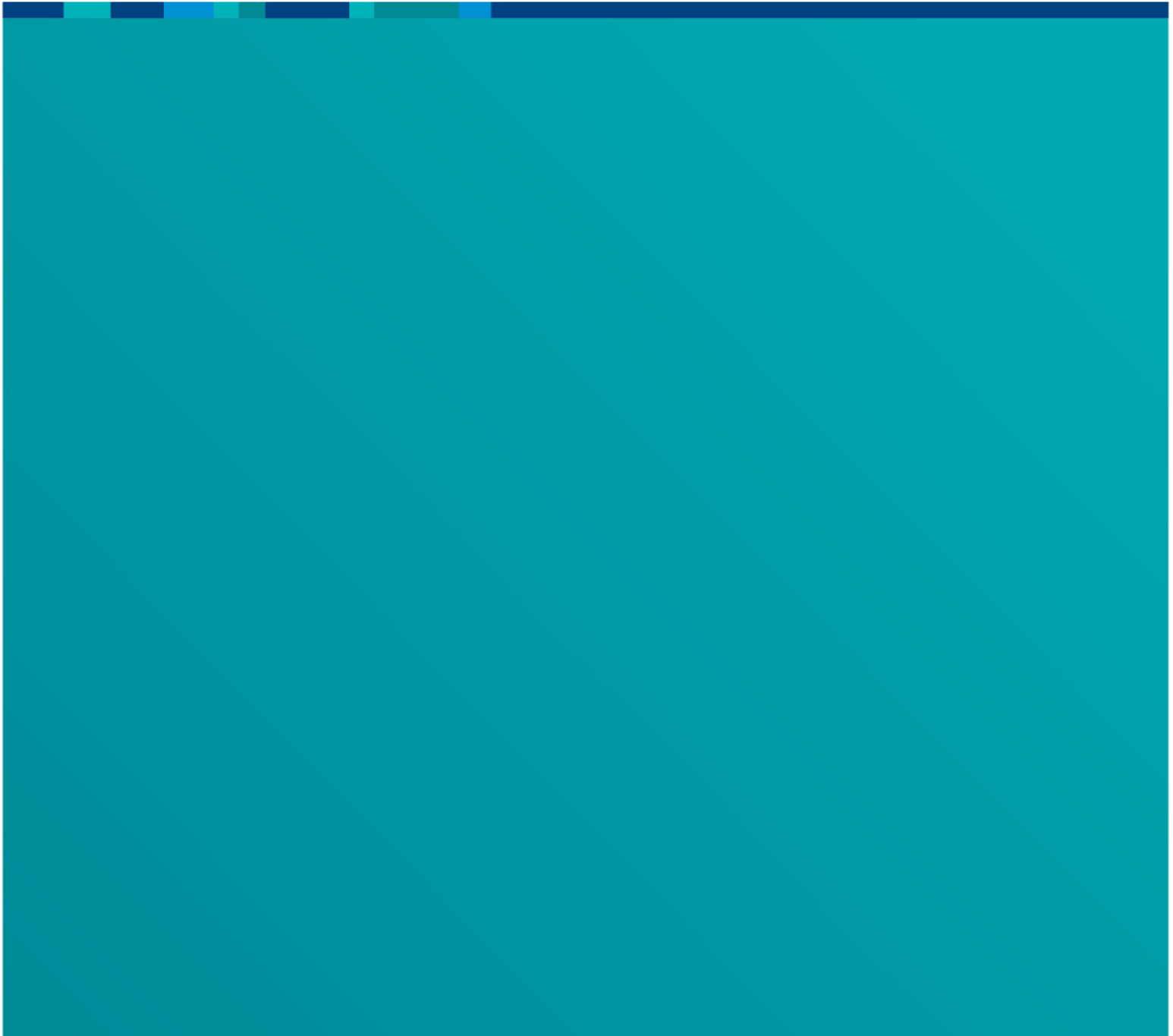




Online prescribing services: Sharing medicines-related information to My Health Record by Default

Consultation Background Paper



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Purpose of this Background Paper

This Background Paper accompanies the public consultation paper on the Government's introduction of requirements for medicines-related information prescribed by online prescribing services to be shared to My Health Record by default.

This paper provides additional detail on the policy, and legislative and system context for medicines-related information sharing in Australia. It also outlines existing privacy and safety safeguards, supporting digital infrastructure, and known limitations and gaps relevant to the proposed reforms.

How to use this paper

This Background Paper is intended to be read alongside the main consultation paper which sets out the policy approach and the specific questions on feedback being sought.

Stakeholders may wish to refer to specific sections of this document depending on their interests or areas of expertise.

Where this paper identifies areas of complexity, limitation, or risk, these are provided to inform discussion and support well-informed consultation responses. References to future stages or longer-term considerations are included for context only and do not represent settled policy positions.

This Background Paper is not intended to pre-empt consultation outcomes or to signal decisions about future reform stages. Views expressed through the consultation process will inform future policy development and implementation planning.

About the Modernising My Health Record (Sharing by Default) Act 2025

This section provides a general overview of the Modernising My Health Record (Sharing by Default) Act 2025 (SBD Act).

Brief overview

In February 2023, the Minister for Health and Aged Care released the [Strengthening Medicare Taskforce Report](#), which recommended that Government ‘modernise My Health Record to significantly increase the health information available to people and their health care providers, including requiring ‘sharing by default’ to MHR for private and public practitioners and services, and to make it easier for people and their health care teams to use at the point of care’.

Introducing requirements to share by default will give people and their healthcare providers improved access to key health information, when it is needed, to improve health outcomes, prevent avoidable adverse health outcomes, and reduce duplicate tests and unnecessary treatments.

On 12 February 2025, the [Modernising My Health Record – Sharing by Default Act 2025](#) passed the Senate without amendment and became law.

What is the purpose of this legislation?

The Health Legislation Amendment (*Modernising My Health Record – Share by Default*) Act 2025 amends the *My Health Records Act 2012* and the *Health Insurance Act 1973* to create a framework for requiring certain health information to be shared to My Health Record by default.

The Act is designed to be flexible. It does not set out which health services, health practitioners or types of health information must be shared. Instead, it allows the Minister to make disallowable rules under the *My Health Records Act 2012* and the *Health Insurance Act 1973* (the Sharing by Default Rules). These Rules specify who must share information and what information must be shared and can be updated over time to include additional health services and information types.

The existing Sharing by Default legislative framework includes compliance mechanisms to support providers in meeting their obligations to share required information. Where obligations are not met, existing legislation allows for a range of responses, including adjustments to

Medicare benefits or the application of civil penalties, depending on the circumstances. As part of implementing Sharing by Default for medicines for online prescribing services, consideration is being given to how compliance arrangements may apply to online prescribing services.

What are the Sharing by Default Rules?

The [Health Legislation Amendment \(Modernising My Health Record – Sharing by Default\) Act 2025](#) responds to recommendations from the Strengthening Medicare Taskforce Report. It provides a framework for key health information to be shared to My Health Record by default. The scope, requirements and exceptions for sharing health information to My Health Record are outlined in the [Health Insurance \(Share by Default\) Rules 2025](#) and the [My Health Record \(Share by Default\) Rules 2025](#), collectively referred to as the Share by Default rules.

Initially, the requirement to share to My Health Record by default will apply to written pathology and imaging reports prepared by (or on behalf of) a pathologist or radiologist. The requirement does not include images. These changes will help ensure consumers and their healthcare providers can access key information through My Health Record to support care. In future, other types of health information may be included in the upload mandate.

Exceptions to uploading to My Health Record

While My Health Record supports routine sharing of health information, information is not uploaded in some circumstances. Under the *My Health Records Act 2012*, a healthcare provider organisation must not upload information if:

- The consumer does not have a My Health Record.
- The consumer requests that the information is not uploaded to their record.
- A consumer's authorised or nominated representative requests that the information is not uploaded.
- A healthcare provider reasonably believes that the information should not be uploaded because of concern for the health, safety or wellbeing of the consumer.
- The information cannot be shared due to circumstances outside the reasonable control of the provider, such as technical system issues that prevent uploads from happening.

Further information on exceptions to uploading to My Health Record can be found on the [Australian Digital Health Agency's website](#).

Medicines and medicines safety in Australia

Medicines in Australia

Medicines are fundamental to healthcare, playing a central role in supporting the health and wellbeing of the Australian community. In 2023–24, more than 226 million Pharmaceutical Benefits Scheme (PBS) subsidised prescriptions were dispensed nationally, reflecting the extensive reliance on subsidised medicines across the community^{1 2}.

Almost seven in ten people in the Australian community have at least one PBS prescription medicine dispensed within a six-month period, rising to more than eight in ten among people with chronic conditions, and to almost all people aged 75 years and over³. These patterns highlight the central role of ongoing pharmacotherapy in the management of chronic disease and ageing.

While PBS data captures the majority of subsidised community prescribing, it does not include private (non-PBS) prescriptions, over-the-counter medicines, or most public hospital inpatient medicines. Private prescriptions therefore represent an important but less visible component of the medicines ecosystem, with evidence indicating their use is increasing in some therapeutic areas. For example, non-PBS prescriptions for antimicrobials more than doubled between 2015 and 2021, highlighting the relevance of private prescribing to medicines safety and quality initiatives⁴.

Given the scale and frequency of medicines use, ensuring that medicines-related information is accurate, up-to-date and accessible at the point of care, is critical to supporting safe prescribing, dispensing and medicines use, regardless of the care setting.

In Australia, medication errors are most likely to occur when people transition between different parts of the health system, particularly at admission to and discharge from hospital. National and international evidence consistently identifies transitions of care as a high-risk period, with evidence suggesting that more than half of clinically significant medication errors occur during

¹ The Pharmaceutical Benefits Scheme (PBS), [Pharmaceutical Benefits Scheme expenditure and prescriptions report 1 July 2024 to 30 June 2025](#), 2025, pbs.gov.au, Department of Health, Disability and Ageing, Australian Government, accessed 4 June 2026.

² Australian Institute of Health and Welfare (AIHW), [Pharmaceutical Benefits Scheme prescriptions over time](#), 2024, AIHW, aihw.gov.au, Australian Government, accessed 4 June 2026.

³ Australian Bureau of Statistics (ABS), [Medications](#), 2022, ABS, abs.gov.au, accessed 4 June 2026.

⁴ Australian Commission on Safety and Quality in Health Care (ACSQHC), [AURA 2023: fifth Australian report on antimicrobial use and resistance in human health](#), 2023, ACSQHC, safetyandquality.gov.au, accessed 4 June 2026.

transitions between settings⁵. Studies have shown that medication histories often contain errors or unintended discrepancies at transitions of care, reflecting variability across settings, patient complexity and reconciliation processes^{5 6}.

Incomplete or unavailable medicines information at the point of care can increase the risk of medicines-related harm where healthcare providers need to make prescribing or treatment decisions without a complete view of a patient's current medicines information. Beyond the point of care, incomplete medicines information also increases risks for patients who may misunderstand how medicines should be used or may not recognise when medicines prescribed through one service should be disclosed to other healthcare providers. Examples of medication errors that could be avoided through better information sharing include:

- prescribing medications that are inappropriate for a person's medical condition, allergies or that interact with other medications and supplements being taken.
- continuing or re-commencing a medication that should have been stopped.

The Australian Government is pursuing a broader national focus on improving medicines safety. Government strategies, including the [National Digital Health Strategy 2023-28](#), identify actions to improve the availability of medicines information at the point of care, strengthen information sharing across digital health systems, and better support safe prescribing and continuity of care in virtual and online settings. Alongside the [Digital Health Blueprint 2023-2033](#), and recent reforms to modernise My Health Record, these actions recognise that safer care depends on key health information being accurate, up to date and available for patients and healthcare providers.

Health system impacts of incomplete medicines information

Incomplete or inadequately shared medicines information has broader system-wide impacts beyond individual patients. Avoidable adverse drug events contribute to unplanned hospital admissions, emergency department presentations and extended lengths of stay, and in some cases, preventable mortality. They also place additional pressure on health services through repeat consultations, diagnostic testing and follow up care to resolve preventable issues. These inefficiencies have cost implications for the health system and can delay care for all people.

⁵ Australian Commission on Safety and Quality in Health Care (ACSQHC), [Medication Management at Transitions of Care Stewardship Framework](#), 2025, ACSQHC, safetyandquality.gov.au, accessed 4 June 2026.

⁶ RA Elliott et al., 'Achieving safe medication management during transitions of care from hospital: time for a stewardship approach', *Australian Prescriber*, 2024, 47(4):106–108., doi:10.18773/austprescr.2024.034.

Poor or incomplete medication histories can contribute substantially to medication errors. One study of hospital admissions shows up to 85 percent medication errors identified were linked to medication history information⁷. These risks are particularly pronounced when people move between different parts of the health system, such as during hospital admission, discharge or transfer between care settings, where more than half of medication errors are estimated to occur⁸.

Incomplete medicines information is also associated with increased hospital utilisation and avoidable readmissions. Patients who leave hospital with one or more medicines missing or inaccurately documented in their discharge information are approximately 2.3 times more likely to be readmitted to hospital than those with complete and accurate medicines information⁹.

Australian research indicates that around 9 percent of emergency department presentations in the community are attributable to adverse drug events, with a majority assessed as potentially preventable¹⁰. Among older Australians, up to 38 percent of unplanned hospital admissions are estimated to be medications-related¹¹, and 40 percent of Australians aged 75 and over are dispensed more than five medicines at the same time, exceeding the OECD average¹².

Internationally, the World Health Organization identifies medication errors as a leading cause of avoidable harm globally, with prescribing, dispensing and information transfer failures contributing substantially to preventable adverse outcomes¹³. Evidence shows that prescribing errors remain common in community care, particularly where medicines information is incomplete or not effectively shared across healthcare providers. In these circumstances, inappropriate prescribing may occur, along with adverse drug reactions caused by interactions between drugs that should not be prescribed together¹⁴.

⁷ KM Gleason et al., 'Results of the Medications at Transitions and Clinical Handoffs (MATCH) study: an analysis of medication reconciliation errors and risk factors at hospital admission', *Journal of General Internal Medicine*, 2010, 25(5):441–447, doi:10.1007/s11606-010-1256-6.

⁸ Advanced Pharmacy Australia and Royal Australian College of General Practitioners, [Medication management at transitions of care: practice update](#), ADPPA and RACGP, 2024, accessed 4 June 2026.

⁹ Department of Health, Disability and Ageing (DHDA), [Guiding principles to achieve continuity in medication management](#), 2022, Australian Government, accessed 4 June 2026.

¹⁰ NJ Brown et al., 'Retrospective study of the prevalence and characteristics of adverse drug events in adults who present to an Australian emergency department', *Emergency Medicine Australasia*, 2022, 34(4):547–554, doi:10.1111/1742-6723.13929.

¹¹ R Lim et al., 'The extent of medication-related hospital admissions in Australia: a review from 1988 to 2021', *Drug Safety*, 2022, 45(3):235–246, doi:10.1007/s40264-021-01144-1.

¹² Australian Institute of Health and Welfare (AIHW), [OECD health care quality and outcomes indicators. Australia 2022–23](#), 2024, AIHW, aihw.gov.au, accessed 4 June 2026.

¹³ World Health Organization (WHO), [Medication Without Harm](#), nd, WHO, who.int.

¹⁴ AJ Wheeler et al., 'Reducing medication errors at transitions of care is everyone's business', *Australian Prescriber*, 2018, 41:73–77, doi:10.18773/austprescr.2018.021.

Current state of medicines-related information sharing

This section describes the types of medicines-related information that are currently captured and shared through national digital systems, noting where availability varies by setting, system or jurisdiction.

Current availability of medicines-related information

Medicines-related information is captured and shared across multiple systems, but only some of this information is available in My Health Record. Depending on the system and the circumstances, medicines-related information that may be available through My Health Record includes:

- **Prescription records:** details of medicines prescribed, including dose instructions and repeats.
- **Reasons for prescribing:** brief information about why a medicine was prescribed, where available, to support safe and informed care.
- **Dispense records:** details of medicines supplied by pharmacies, including repeat information.
- **PBS/ Repatriation Pharmaceutical Benefits Scheme (RPBS) information:** records added after claims are finalised (not real time).
- **Real Time Prescription Management (RTPM):** details of monitored medicines (those requiring authorised scripts), with different monitored medicines lists and practitioner requirements across states and territories.
- **Hospital discharge summaries and shared health summaries** including event summaries and specialist letters: which may include medicines-related information but are often uploaded as PDFs.
- **Pharmacist shared medicines lists, and individual-entered medicines-related information:** (point-in-time records).

More information about My Health Record, including how information is accessed and managed, is available on the [Australian Digital Health Agency](#) website.

Even where medicines-related information exists, individuals and healthcare providers can still be unable to access an up-to-date, real-time list of current and past medicines when they need it.

This creates gaps at the point of care and can result in incomplete medicines-related information being available for clinical decision-making.

As mentioned above, there may be some cases where safe care may also depend on having enough clinical context to understand why a medicine was prescribed. Consultation seeks views on whether any additional information should be included, and what safeguards may be needed where this could reveal sensitive health information.

Where medicines-related information comes from

Australia already has national digital infrastructure and systems that support prescribing and dispensing. They act as important foundations for improving medicines safety, but they do not always provide a single, up-to-date view of a person's medicines history across care settings.

Electronic prescribing (ePrescribing)

Electronic prescribing known as ePrescribing, is available nationally as an alternative to paper-based prescriptions, with more than 370 million electronic prescriptions generated since its rollout in 2021¹⁵.

When used, ePrescribing supports more reliable digital capture of prescribing information and can reduce reliance on handwritten, paper-based prescribing. However, paper-based prescribing continues to account for a significant proportion of prescriptions in Australia. More information about ePrescribing is available on the [Department of Health, Disability and Ageing](#) website.

National Prescription Delivery Service (NPDS)

Electronic prescribing relies on the NPDS, a prescription delivery service. More than 95 percent of eligible prescriptions use the NPDS¹⁶. The NPDS supports the secure exchange of electronic prescriptions between prescribers and dispensers. However, information held within the service is not automatically available in MHR and only becomes visible where prescription or dispensing records are separately uploaded by participating healthcare providers. More information about NPDS is available on the [Department of Health, Disability and Ageing](#) website.

¹⁵ Australian Digital Health Agency (ADHA), [Exploring prescriber, dispenser and consumer use of electronic prescriptions: an Australian snapshot](#), ADHA, digitalhealth.gov.au, 2023, accessed 4 June 2026.

¹⁶ Department of Health and Aged Care (DHAC), [National Prescription Delivery Service \(PDS\) – fact sheet for clinicians and pharmacists](#), 2023 DHAC, Australian Government, health.gov.au, accessed 4 June 2026

Active Script List (ASL)

The ASL can support medicines management by securely storing active electronic prescriptions in one place¹⁷. A person must actively register for an ASL, and participation is voluntary. ASL can support individuals and their care teams by making active prescriptions easier to manage and reducing reliance on a single token or message. Unlike My Health Record, the Active Script List only contains active electronic prescriptions and does not provide a longitudinal medicines history or capture dispensing information. More information about ASL is available on the [Department of Health, Disability and Ageing](#) website.

Real Time Prescription Monitoring (RTPM)

States and territories operate Real-Time Prescription Monitoring (RTPM) systems that support safer prescribing and dispensing of high-risk and monitored medicines. RTPM is an important safeguard that enhances clinical safety. Currently, the use of RTPM is governed by relevant laws and arrangements in each state and territory. As a result, requirements for using RTPM vary between states and territories. For example, RTPM use is not mandatory for prescribers and dispensers in all jurisdictions, and data is not yet shared consistently across borders.

RTPM and My Health Record serve different but complementary purposes. RTPM supports the monitoring and management of some high-risk and monitored medicines at a state and territory level. By contrast, My Health Record enables the sharing of healthcare information nationally to support continuity and safety of care regardless of jurisdiction. More information about RTPM is available on the [Department of Health, Disability and Ageing](#) website.

International examples

Many countries are strengthening how medicines-related information is shared to reduce medication-related harm. International examples show the value of nationally coordinated shared medicines lists, clear governance arrangements, and wide consultation with people and healthcare providers. Nordic countries, including Denmark, Finland, Norway and Sweden, are introducing digitally shared medication lists¹⁸.

These lists aim to give healthcare professionals access to accurate and up-to-date medicines-related information, helping to improve patient safety and reduce medication errors. Evidence

¹⁷ Australian Digital Health Agency (ADHA), [Electronic prescriptions](#), 2026, ADHA, digitalhealth.gov.au, accessed 4 June 2026.

¹⁸ H Berntsen, [Norway, Sweden, Denmark and Finland introduce digitally shared medication lists](#), 2023, forskning.no, accessed 4 June 2026.

from these countries suggests that electronic prescriptions alone do not always provide a complete or current picture of how medicines are being used.

These international examples reflect a broader recognition that medicines safety is strengthened when medicines-related information is consistently shared across care settings, beyond what electronic prescribing alone can provide.

Existing safeguards and protections for privacy and safety

This section outlines current My Health Record legislation and established Commonwealth, state and territory laws that provide privacy and safety protections that apply to health information, including medicines-related information.

Privacy Protections

My Health Records Act 2012

My Health Record is an individual-controlled national electronic health record. A person can manage their own privacy settings, including restricting access to their records or specific documents and choosing notification settings.

The *My Health Records Act 2012* provides specific protections for information held in My Health Record. Personal control is a central feature of the system. Individuals can restrict access to their record, and to specific documents in it, remove documents, receive notifications about access, and cancel their record at any time.

Under the *My Health Records Act 2012*, healthcare providers do not usually need to ask for consent each time before uploading information to My Health Record. But information may not be uploaded in some circumstances, including if a person requests this, or if a prescribed state or territory privacy law requires otherwise. This helps support timely sharing of important health information while keeping existing privacy protections and personal controls in place.

To be eligible to participate in My Health Record a prescriber's or pharmacist's organisation must register for a Healthcare Provider Identifier–Organisation (HPI-O) from the Healthcare Identifiers Service (HI Service). Individual providers within the organisation also need to have a Healthcare Provider Identifier–Individual (HPI-I) if they are authoring clinical information for uploading to My Health Record.

Use of healthcare identifiers is governed by the *Healthcare Identifiers Act 2010* (HI Act). This Act requires an organisation to take reasonable steps to protect healthcare identifiers from misuse, loss, unauthorised access, modification or disclosure.

Individual Controls for My Health Record

These new requirements will not change the strong privacy protections and controls already in place, including:

- setting notifications to see when certain activities occur, such as when registered healthcare providers access their record or when certain health information is added to their record¹⁹.
- using privacy controls including setting access codes, which limits who can access their record or specific documents in their record.
- removing a document from their record.
- hiding and restoring a document within their record.
- viewing the access history for their record to see which organisations have viewed or added to their record.

These protections provide a strong foundation for privacy. Helping people understand how they can best use these privacy settings will increase confidence in the system.

It is acknowledged that these controls may affect visibility of medicines-related information to health providers at the point of care. However, this initiative focuses on addressing the many situations where medicines information is unintentionally missing or not shared, while continuing to respect existing privacy protections and individual controls.

Privacy Act 1988

The *Privacy Act 1988* also imposes obligations (including the [Australian Privacy Principles](#)) on Commonwealth agencies and the private sector relating to collection, use and disclosure, access, storage, security and accuracy of personal information, with additional obligations for sensitive information such as health information.

Health service providers also have privacy obligations and professional duties when handling health information, including when information is downloaded from national systems into local

¹⁹ Australian Digital Health Agency (ADHA), [Notification and message settings](#), 2024, ADHA, digitalhealth.gov.au, accessed 4 June 2026.

clinical systems. These protections support appropriate use and help build trust in digital health systems.

Office of the Australian Information Commissioner

The Office of the Australian Information Commissioner (OAIC) is Australia's independent regulator for privacy. In the context of My Health Record, the OAIC's role is to oversee the privacy aspects of the My Health Record system including the authorised collection, use and disclosure of health information by system participants.

State and Territory Privacy Legislation

States and territories have their own privacy laws for public sector agencies, and the Privacy Act 1988 applies to private sector health service providers across Australia. In New South Wales, Victoria and the Australian Capital Territory, private sector health service providers must comply with both Commonwealth and state or territory privacy laws when handling health information. Queensland, the Northern Territory and Tasmania have privacy legislation that applies only to their public sector, including public sector health service providers.

Preserved Privacy Laws

A preserved privacy law is a state or territory disclosure restriction that is not overridden by the MHR Act. The preserved privacy laws are specified by regulation 3.1.1 of the *My Health Records Regulation 2012*.

The MHR Act authorises registered healthcare provider organisations to upload health information to the MHR system, subject to two conditions – that there is no instruction by the consumer not to upload the information and that consent has been obtained if a preserved privacy law applies²⁰.

Most states and territories have laws prohibiting the disclosure of certain types of identifiable health information without consent. Uploading information to the My Health Record (MHR) system is a disclosure. The *My Health Records Act 2012* (MHR Act) overrides those disclosure restrictions to allow registered healthcare provider organisations to upload health information to the MHR system without obtaining consent, except where there is a preserved privacy law in effect.

²⁰ Clause 9 of Schedule 1 to the *My Health Records Act 2012*

There are no preserved privacy laws in Western Australia, Tasmania, Northern Territory, South Australia and Victoria. Registered healthcare provider organisations in those locations do not need to obtain consent to upload information to the MHR system.

There are some preserved privacy laws in the Australian Capital Territory^{21 22}, New South Wales²³ and Queensland^{24 25 26 27 28 29}. Registered healthcare provider organisations in those locations may need to obtain consent in a particular manner from the consumer or identified third party before uploading information to the MHR system, depending on the type of health information.

Failure to obtain consent when required may incur penalties under the Public Health Act of the state/territory, the MHR Act and/or the *Privacy Act 1988*.

Safety and Clinical Governance

Safety protections for medicines use are supported through national standards, clinical governance frameworks and advisory bodies.

National Safety and Quality Health Service (NSQHS) Standards and national guidance (third edition in development)

Medication safety is supported through national standards, guidance and clinical governance arrangements. The NSQHS Medication Safety Standard aims to ensure healthcare providers safely prescribe, dispense and administer appropriate medicines, monitor medicine use, and that people are informed about medicines and understand their medicines needs and risks³⁰.

The Australian Commission on Safety and Quality in Health Care is developing the NSQHS Standards (third edition), with further consultation scheduled for 2026.

²¹ Section 110 of the Public Health Act 1997 [ACT]

²² Section 111 of the Public Health Act 1997 [ACT]

²³ Section 56 of *Public Health Act 2010* [NSW]

²⁴ Section 55 of the *Public Health Act 2005* [Qld]

²⁵ Sections 77-79 of the *Public Health Act 2005* [Qld]

²⁶ Sections 175-177 of the *Public Health Act 2005* [Qld]

²⁷ Sections 220-222 of the *Public Health Act 2005* [Qld]

²⁸ Sections 238-240 of the *Public Health Act 2005* [Qld]

²⁹ Sections 105-107 of the *Public Health Act 2005* [Qld]

³⁰ Australian Commission on Safety and Quality in Health Care (ACSQHC), [Medication Safety Standard](#), 2026, ACSQHC, safetyandquality.gov.au, accessed 4 June 2026.

National Clinical Governance Committee and Expert Advisory Groups

National clinical governance arrangements, including the National Clinical Governance Committee for Digital Health³¹ and its Expert Advisory Groups, provide advice on safe and effective use of digital health systems and clinical information. These structures help identify emerging risks, develop guidance and support alignment between policy, clinical practice and digital capability.

Australian Health Practitioner Regulation Agency (Ahpra) and National Boards

The Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards regulate registered health practitioners in Australia. They set professional standards, codes of conduct and registration requirements that apply across all settings, including telehealth and online prescribing³². These frameworks require prescribers to practise safely, competently and ethically, including taking reasonable steps to obtain and consider relevant clinical information before prescribing. This includes reviewing a person's medicines history, identifying potential interactions or contraindications, and prescribing in a way that supports continuity of care.

Ahpra and the National Boards also support safe prescribing through professional guidance, including the National Prescribing Competencies Framework, which outlines expectations for high quality prescribing practice across professions and models of care. These regulatory and professional standards operate alongside digital health reforms and provide an important safeguard to support safe medicines use, including in online prescribing services.

National Prescribing Competency Framework

The National Prescribing Competencies Framework sets out national expectations for all health professionals who prescribe medicines, regardless of profession or setting. The Framework describes prescribing as a person-centred, iterative process that includes information gathering, clinical and shared decision-making, communication, and monitoring and review.

The Framework emphasises reviewing a person's medicines history, making shared decisions with patients, communicating clearly, and monitoring outcomes over time. These steps are especially important where care is delivered digitally, and where prescribers may not be part of a person's usual care team.

³¹ Australian Digital Health Agency (ADHA), [National Clinical Governance Committee for Digital Health](#), 2026, ADHA, digitalhealth.gov.au, accessed 4 June 2026.

³² Australian Health Practitioner Regulation Agency (Ahpra), [Information for practitioners who provide virtual care](#), 2024, Ahpra, ahpra.gov.au, accessed 4 June 2026.

The Framework also recognises the increasing use of digital systems and virtual care, and the need for prescribers to use digital health information appropriately within their scope of practice and relevant legislative settings. These competencies provide an important clinical governance foundation that complements these reforms to improve the availability and use of medicines-related information through My Health Record, including in online prescribing settings.

Existing Commonwealth and jurisdictions systems and legislation

This section provides an overview of the existing laws and systems that support medicines-related information sharing, and how these arrangements operate in practice. It highlights current capabilities and limitations that are relevant to the Sharing by Default approach for online prescribing services.

The system and laws that support sharing medicines-related information

Medicines safety has been a national Government priority for many years, with increasing emphasis on digital systems that support safer prescribing, dispensing and continuity of care^{33 34}³⁵. With the aim to reduce preventable harm, improve the safe and effective use of medicines, and support safer prescribing and dispensing across the health system. Digital tools play an important role in achieving these goals, especially by giving people access to reliable prescription and dispensing information.

Australia already has national digital health infrastructure and legislative frameworks in place that support the sharing of health information across care settings.

The *My Health Records Act 2012*, alongside reforms introduced through the *Modernising My Health Record (Sharing by Default) Act 2025*, is intended to support more consistent and clinically useful information sharing while maintaining individual controls. These reforms aim to address known gaps and improve the availability of key health information, including medicines-related information.

³³ Department of Health and Aged Care (DHAC), [The Digital Health Blueprint and Action Plan 2023–2033](#), 2023, Australian Government, accessed 4 June 2026.

³⁴ Pharmaceutical Society of Australia (PSA), [Medicine safety: take care](#), psa.org.au, 2019, accessed 4 June 2026.

³⁵ Australian Digital Health Agency (ADHA), [National Digital Health Strategy](#), 2023, ADHA, digitalhealth.gov.au, accessed 4 June 2026.

To make sharing work reliably, national digital infrastructure is essential. Consistent use of national data and terminology standards, and effective use of healthcare identifiers will be critical to provide accurate matching, interoperability and data quality across systems. When identifiers are missing or standards are inconsistently implemented, medicines-related information may not upload, may be incorrectly linked, or may not be available in a form that supports safe and timely use at the point of care.

Data and terminology standards

National standards for health information and medicine names, including the Australian Medicines Terminology (AMT), support consistent recording and sharing of medicines information. This supports safer care and clearer communication across the health system. Use of these standards aligns with the National Healthcare Interoperability Plan 2023–2028, which seeks to support safer, more secure and more consistent sharing of health information nationally.

Consistent application of national data and terminology standards is critical to ensuring medicines-related information is accurately captured, matched and shared across systems. How these standards are used in online prescribing settings will be an important consideration for the design and implementation of sharing by default reforms.

Healthcare Identifiers

The *Healthcare Identifiers Act 2010* (HI Act) and the Healthcare Identifiers Service support the use of unique numbers for people and healthcare providers. The HI Act sets out when healthcare identifiers may be used and disclosed and requires organisations to take reasonable steps to protect them from misuse, loss, unauthorised access, modification or disclosure.

Healthcare identifiers are critical because they can help to make sure medicines information from online prescribing and dispensing is linked to the right person and provider and can be shared safely through national digital health systems, including My Health Record. Use or disclosure of healthcare identifiers in contravention of the HI Act may result in penalties and may also constitute a privacy breach.

Current mechanisms for sharing medicines-related information

Australia has existing digital health tools and systems in place that support medicines-related information sharing. Examples include electronic prescribing and dispensing systems, the Active Script List, and My Health Record which currently has 1.2 billion medicines-related documents³⁶. More information on existing national digital infrastructure and tools that supports the sharing of medicines-related information can be found in the Consultation Background Paper.

Sharing information safely depends on being able to match the right information to the right person and healthcare provider. Healthcare Identifiers already help do this. Recent reforms have expanded who can use these identifiers and what they can be used for making it easier for health systems to work together. National data and terminology standards also help ensure medicines information is recorded in a consistent way, so it can be understood across different systems.

This is making it possible to increase availability and consistency of the sharing of medicines information, but gaps remain, particularly in online prescribing services, due to variability in healthcare provider participation, workflows, and information sharing practices.

Factors that can contribute to these gaps include:

- **Identifier barriers:** The ability to share a person's medicines-related information generally requires the ability to successfully match the person's identifying information in both systems, often through the use of an Individual Healthcare Identifier (IHI). If a provider does not know the patient's IHI, they may not be able to share information to My Health Record.
- **Paper prescribing workflows:** Handwritten prescriptions are not shared through ePrescribing tools. They also often do not include the patient's IHI, making it less likely that dispensing pharmacists can share information to My Health Record when the patient collects their medication.
- **Software capability and configuration:** Not all systems support automated uploads to My Health Record, and "do not upload" settings can prevent uploads if applied.

³⁶ Australian Digital Health Agency (ADHA), [My Health Record statistics](#), 2026, ADHA, digitalhealth.gov.au, accessed 4 June 2026.

Implementation

This section focuses on identified practical considerations for implementing requirements to share medicines-related information by default in online prescribing settings. It explores how these requirements would need to fit with existing systems, workflows, and clinical practice.

Human factors and clinical use of information

For medicines-related information to improve safety, it also needs to be visible, understood and used in practice as part of clinical decision-making. This depends on how information is shown in systems, how well it fits into everyday clinical workflows, and whether clinicians feel confident using it when caring for patients.

Viewing and using medicines information in practice

Making medicines-related information available does not, on its own, ensure it is consistently viewed or used. In practice, whether information is accessed and relied on can be influenced by clinical workflow, system usability, and the context in which care is delivered.

Are systems ready to share medicines-related information?

Implementation will depend on whether online prescribing services can capture medicines-related information accurately and share it to My Health Record as part of routine care. It will also depend on how well services can connect to national digital health infrastructure and use it in a way that supports safe and timely care.

Online prescribing services connecting to My Health Record

To share information by default, online prescribing services need to be able to connect to My Health Record and related national infrastructure. This includes using Healthcare Identifiers, national data and terminology standards, and secure interoperability requirements.

Clinical information systems are also central to reliable medicines-related information sharing. Through information available in My Health Record, these systems can enable viewing of medicines-related information by healthcare providers to support safe prescribing and dispensing.

More understanding is needed on the readiness of online prescribing services to integrate with My Health Record. This includes the guidance, technical support or transitional arrangements that may be needed to ensure safe and consistent participation.

Electronic prescribing and dispensing workflows

Electronic prescribing is an important part of the broader digital medicines ecosystem. It supports more consistent and structured digital capture of prescribing information at the point of care. While electronic prescribing and My Health Record are separate systems, improved digital capture of medicines information can support safer and more efficient clinical and dispensing workflows. Prescription and dispense records can be uploaded to My Health Record regardless of whether the original prescription was electronic or paper-based. However, paper or handwritten prescriptions are still widely used. Paper prescriptions do not always lead to gaps in information. Many are still processed through digital systems, which means prescribing and dispensing information can still be captured and shared. For example, many paper prescriptions are barcoded for scanning into electronic prescribing systems, like the National Prescription Delivery Service.

Gaps are more likely where prescriptions are created or handled outside those systems. Over time, these reforms will need to work across different prescribing formats, so paper-based processes do not stop more complete medicines information from being shared.

Using Individual Healthcare Identifiers consistently

Consistent capture and use of Individual Healthcare Identifiers (IHIs) is essential to accurate matching of medicines-related information to the correct individual. Missing or incorrect identifiers can prevent medicines records from being uploaded or linked, contributing to information gaps.

Glossary

Active Script List (ASL)

A token management solution which securely stores active electronic prescriptions in one place and can be accessed by authorised healthcare providers with the person's consent.

Asynchronous care

Healthcare delivered where communication between a person and their healthcare provider does not occur in real time. This can include online questionnaires, secure messaging or request-and-response services used in some digital or online prescribing models.

Best possible medication history

A list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over the counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information. Resolved

Electronic prescribing (ePrescribing)

The digital creation and transmission of prescriptions that is an alternative to paper prescriptions which support safer access to medicines.

Healthcare Identifiers (HI Service)

A national service that issues unique identifiers to individuals and healthcare providers to support accurate matching and secure sharing of health information.

Healthcare Provider Identifier- Individual (HPI-I)

A unique identifier assigned to an individual healthcare provider.

Healthcare Provider Identifier-Organisation (HPI-O)

A unique identifier assigned to a healthcare provider organisation.

High-risk medicines

Medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating. At a minimum, the following classes of high-risk medicines should be considered:

- Medicines with a narrow therapeutic index.
- Medicines that present a high risk when other system errors occur, such as administration via the wrong route.

Individual Healthcare Identifier (IHI)

A unique identifier assigned to an individual to ensure their health information is correctly linked across digital health systems.

Medicine

A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.

Medicines-related information

Information about medicines prescribed, dispensed or used by an individual, including details needed to support safe prescribing, dispensing and continuity of care.

Medicines-related problem

Any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease specific, laboratory test-specific and patient-specific information. Medicines-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Non-compliance.

Medication reconciliation

A formal process of obtaining and verifying a complete and accurate list of each patient's current medicines and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.

Medication review

A systematic assessment of medication management for an individual patient that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change. It includes the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medicines-related problems and reducing waste. Medication review may be part of medication reconciliation. See also home medicine reviews (HMRs) and residential medication management reviews (RMMRs).

Medication safety

Is about reducing medication adverse events and errors by establishing and using systems to ensure:

- Clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use
- Consumers are informed about medicines and understand their own medicine needs and risks.

My Health Record

Australia's national digital health record system that allows individuals and their healthcare providers to securely access and share key health information.

National Medicines Record

A national reform to strengthen medicines safety by improving access to accurate, up-to-date medicines information across all care settings, building on existing national digital health infrastructure.

Online prescribing services

Healthcare services that prescribe medicines through telehealth or digital platforms, including phone, video or online consultations, where the prescriber may not have an existing face-to-face relationship with the patient.

Real-Time Prescription Monitoring (RTPM)

Clinical decision support tool for prescribers and pharmacists that provides visibility on certain monitored, high-risk medicines prescribed and dispensed for a person within their jurisdiction.

Sharing by Default

Policy that requires certain health information to be shared to My Health Record by default, subject to defined exceptions and individual controls.

Stigma

Stigma refers to the negative attitudes and beliefs that can hinder individuals, particularly those affected by bloodborne viruses (BBVs) and sexually transmissible infections (STIs), from accessing healthcare and receiving support. It can lead to increased social isolation, discrimination, and a lack of trust in healthcare services.

Synchronous care

Healthcare delivered where communication between a person and their healthcare provider occurs in real time. This includes consultations conducted by phone, video or other live communication technologies that allow immediate interaction, assessment and clinical decision-making.

Telehealth

Health services delivered using information and communication technologies, such as videoconferencing or phone calls.

Transitions of care

Any interaction between a patient and clinician, or between clinicians, occurring remotely with a transition of care is when all or part of a person's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or all of their health care. It may be temporary – to manage a brief illness, or long term – due to a permanent change in health status. Transitions of care may occur within and between healthcare locations, settings, care delivery types, levels of care and involve a range of health care providers.

Virtual care

Any interaction between a patient and clinician, or between clinicians, occurring remotely with the use of information technologies.