CANNABIS COUNCIL AUSTRALIA

Online Prescribing Services: Sharing medicines-related information to My Health Record by Default - Cannabis Council Australia submission

Question	Response
1. Is the scope of the policy clear, including who it applies to, what information would be shared, and how it would be shared to My Health Record?	**Yes.** CCA supports improving the visibility and availability of medicines information, particularly where people access care through direct-to-consumer or online prescribing models outside their usual care team. However, this is a highly technical reform and requires a clearly defined scope, consistent definitions (including patient/consumer/people), and explicit guidance on who and/or what is captured, what information must be shared, how it will be shared to My Health Record, and whether any services, medicines or circumstances are excluded or treated differently. CCA flags separating online prescribing from hybrid and face-to-face models may create a two-tiered approach, particularly when many models of care already combine in-person care, telehealth and digital prescribing. In view of the real risk of fragmentation of a person's My Health Record, it would be helpful to have a clear timeline for the expansion of share by default arrangements for the totality of medicines information.
2. Are there any types of online prescribing services that should be excluded from these requirements?	**No.** No, not as a broad exemption. CCA considers that government should take a whole-of-system approach to improving quality, safety and continuity of care across prescribing models.

3. How should people's privacy and individual choice be balanced with safe and coordinated care if medicines information prescribed by online prescribing services is shared to My Health Record by default?	Privacy and individual choice should be protected, while ensuring that clinically relevant medicines information is available to support safe prescribing, dispensing and coordinated care. In all settings, consumers should be clearly informed before prescribing occurs as to what information will be shared, where it is held/stored, who may access it, and what controls are available. This should not be relegated to fine print statements, particularly in online settings. Information should be provided in plain language and, where possible, verbally within the prescribing workflow. Consumers should retain meaningful controls, including My Health Record access controls and, where appropriate, the ability to request that information not be uploaded where sharing may create a safety, wellbeing or stigma-related risk. This is particularly important for medicines associated with stigma, including medicinal cannabis.
4. What types of medicines-related information should be shared to My Health Record to support safer and more coordinated care?	Medicines information should be sufficient to support safe prescribing, dispensing and continuity of care without creating unnecessary data burden. This should include medicine name, active ingredient, dose, route of administration, quantity, directions for use, date prescribed, date supplied where relevant, prescriber details, dispensing pharmacy where relevant, and intended therapeutic purpose or clinical indication where clinically appropriate. CCA notes that the reason for prescribing may be sensitive and should be handled carefully, particularly where it could disclose sensitive or stigmatised health information. For medicinal cannabis, the high volume of unapproved products and the absence of a standardised dose metric can limit the consistency and usefulness of medicines information. CCA is advocating for reforms that improve standardisation, including clearer product and dose information, to support safer prescribing, dispensing and continuity of care.

5. Should stronger requirements or safeguards apply for higher-risk medicines, such as opioid pain medicines, sedatives, benzodiazepines, stimulant medicines, or medicinal cannabis?	**No.** Additional medicine-specific safeguards should not be created through My Health Record. Existing regulatory controls for Schedule 8 and other higher-risk medicines are already designed to manage prescribing and dispensing risks. The role of My Health Record should be to make relevant risk information visible and clinically useful, not to create a parallel compliance process. This could include clear display of medicine schedule, active ingredient, strength, dose, prescribing and dispensing history, multiple prescriber risk and relevant clinical context where appropriate. For medicinal cannabis, this should include product and cannabinoid information where available, while recognising that many products are unapproved and dose information is not yet standardised. Indeed, we recommend that if a patient is prescribed any unapproved good, the unapproved status of the product should be flagged in a person's My Health Record. Government should also consider whether, for higher-risk medicines, the reform should support appropriate viewing of relevant medicines information, not only upload. This could help ensure prescribers and pharmacists use available information to identify interactions, duplicate therapy, multiple prescribers and other safety concerns before prescribing or dispensing.
6. Are there medicines that should be exempt or treated differently due to potential sensitivity or risk?	**No.** No medicine category should be broadly exempted from or treated differently under the proposed sharing requirements solely because of the medicine involved. CCA supports a consistent approach to medicines information, with any exception to default uploading based on the individual patient's circumstances, preferences and safety risks. For some patients, sharing particular medicines information may create a risk of harm, including where there is intimate partner violence, coercive control, shared device access, or access to My Health Record by carers or family members. Patients may also have legitimate concerns about stigma, discrimination or other adverse consequences arising from disclosure of sensitive medicines information, including medicinal cannabis. Government should therefore ensure that patients have clear information and meaningful, usable controls. This should include a clear distinction between access controls, which determine who can view information already uploaded, and upload controls, which determine whether information is added to My Health Record in the first place. A share-by-default model should not place the full burden

	on patients to identify and manage risks only after information has been uploaded. The preferred approach is to retain default sharing to support medicines safety, while allowing limited, patient-controlled exceptions where uploading information may create a credible risk of harm. These arrangements should be nationally consistent, easy to use and supported by clear guidance for patients and healthcare providers.
7. Are there any risks specific to online prescribing services, compared to other prescribing settings, that this proposal should address?	**No.** No risks identified in the consultation are inherently unique to online prescribing. Fragmented care, incomplete medicines histories, multiple prescribers and limited continuity with a person's usual GP or specialist can also occur across face-to-face, hybrid and increasingly casualised primary care models. Online prescribing can improve access, convenience, privacy and affordability, particularly for people who cannot readily access an appropriate local practitioner. It may also make existing system weaknesses more visible where care occurs across different providers or platforms. However, the underlying risk is not the mode of consultation itself; it is the absence of complete, timely and interoperable medicines information across the health system. The proposal should therefore avoid treating online services as a uniquely risky category. It should instead improve continuity of care and shared medicines visibility across all prescribing settings, while recognising the different workflows and implementation needs of online, hybrid and face-to-face services.
8. Why do people use online prescribing services?	People use online prescribing services for access, convenience, privacy, affordability and speed. Online models can reduce practical barriers associated with travel, appointment availability, mobility, work and caring responsibilities, and difficulty accessing an appropriate local practitioner. For medicinal cannabis patients, access to relevant clinical expertise is particularly important. Some patients use dedicated online clinics following referral from their usual GP, while others do so because their regular practitioner does not prescribe medicinal cannabis, lacks confidence or experience in this area, or is unwilling to discuss it as a treatment option. Stigma may also influence how and where patients seek care. Some patients perceive dedicated online services as

	more informed, respectful and less judgemental. However, the same concerns about stigma may make patients reluctant to have medicinal cannabis information automatically shared across the broader health system, particularly where they are concerned about how it may be interpreted by other practitioners or used beyond the immediate treating relationship. CCA supports safe, clinically governed online models of care that are integrated with broader health system information flows and preserve meaningful patient choice and control.
9. What matters most to patients who use online prescribing services?	Patients value timely access, convenience, affordability, privacy, respectful care, clinical legitimacy and continuity of treatment. For medicinal cannabis patients, stigma remains a significant issue. Many consumers want confidence that their information will be handled safely and not used in ways that expose them to discrimination, judgement or unnecessary barriers to care. Clear information and meaningful control over health information will be important to community trust. Government should assess whether broader visibility of medicines information could have unintended consequences beyond clinical care, including in relation to life insurance, income protection, professional indemnity and other settings in which health information may be requested, disclosed or interpreted. Patients should be clearly informed about the limits of My Health Record access and any circumstances in which information may be disclosed outside direct care.
10. What impacts or challenges should government consider before implementing this reform?	Government should consider this reform as part of the broader national medicines information ecosystem, not as a standalone fix for one part of the system. Existing and planned systems, including My Health Record, real-time prescription monitoring systems such as SafeScript, the National Prescription Delivery Service and the proposed National Medicines Record, should be interoperable, minimise duplication and support a coherent national medicines architecture. Medicines information should have a single authoritative source and surface consistently across the different platforms used by prescribers and pharmacists, without requiring duplicative data entry or repeated checking of disconnected systems.

	Implementation should reflect the different workflows of healthcare professionals. Pharmacists generally work within dispensing software and need relevant information to appear seamlessly at the point of supply. Prescribers may move between practice management systems, prescribing platforms, My Health Record and state-based monitoring systems. The reform should therefore be integrated into existing software and clinical workflows rather than requiring practitioners to access separate platforms or manually transfer information. The design of alerts and the user interface will also be critical. Excessive or poorly targeted notifications may contribute to alert fatigue and reduce attention to clinically significant information. Information should be clearly prioritised according to its relevance and urgency, with user testing involving prescribers, pharmacists, practice managers and patients before implementation. Implementation should also account for medicinal cannabis, where the high volume of unapproved products limits standardisation of product, dose and clinical information. Patients may also experience stigma from healthcare practitioners, creating a risk that they withhold information, disengage from care or seek cannabis illicitly to avoid disclosure. The reform should therefore be supported by targeted guidance for healthcare practitioners on respectful, non-judgemental conversations when medicinal cannabis or other potentially stigmatised medicines appear in a patient's record. Patients also need clear information about their autonomy, My Health Record privacy controls and the safety benefits of sharing accurate medicines information with treating clinicians.This should include a clear explanation of what information will be uploaded, who may access it, and the difference between controls that prevent information from being uploaded and controls that restrict access after upload. Government should also clarify whether consent must be revisited when the scope, purpose or types of information shared change. Government should assess potential unintended consequences beyond direct clinical care, including patient concerns about how medicines information may be interpreted or disclosed in relation to life insurance, income protection, professional indemnity or other settings. Implementation should not commence until the technical architecture, data fields, terminology and system specifications are settled. Stakeholders identified software

	readiness, workflow burden, cost, patient consent and communication, data quality, product identification, inconsistent terminology, privacy concerns and variable provider capability as key risks. Government should provide clear implementation guidance, patient-facing materials, clinician education and a realistic transition period, supported by a national change-management plan that clearly allocates responsibilities across software vendors, healthcare organisations, practice managers, practitioners, pharmacists and patients. A transition period of at least six to twelve months should commence only after the final technical requirements, data standards and system specifications are published. A longer period may be required where substantial software development, testing, accreditation or workforce preparation is necessary. The reform should also be piloted and reviewed before full implementation.This should avoid creating a tiered approach that regulates online services differently from face-to-face or hybrid care.
11. Is it practical for online prescribers to share medicines information by default using current digital systems?	**Yes.** Yes, if the system architecture is designed properly and there is a sufficient lead time. It should be practical if upload processes are automated, integrated into existing clinical software and do not require duplicative manual entry. The reform should not create significant administrative burden for prescribers or pharmacists. Government should ensure My Health Record, the National Prescription Delivery Service, SafeScript and other real-time prescription monitoring systems, and the proposed National Medicines Record work together. A single national medicines architecture is required as against multiple overlapping systems.
12. How is patient clinical information and history currently used to inform prescribing and dispensing decisions?	CCA is not a prescribing or dispensing organisation. However, safe prescribing and dispensing generally relies on access to current medicines, allergies, relevant diagnoses, previous adverse events, possible interactions, prescribing history and existence of multiple prescribers or pharmacies. The reform should support clinicians to access this information efficiently and consistently without requiring them to check multiple disconnected systems.

13. How might sharing medicines information to My Health Record change clinical workflows?	Sharing medicines information could improve clinical decision-making by giving prescribers, pharmacists and other treating practitioners a more complete view of a person's medicines history. It may also promote communication between treating doctors. However, workflow impacts will depend on system design. If clinicians are required to check or update multiple systems, the reform may increase administrative burden and reduce uptake. The design should support automatic upload, clear alerts, minimal duplication and integration with existing prescribing and dispensing workflows.
14. Are you using My Health Record prior to prescribing or dispensing medicines?	**No.** Not applicable. CCA does not prescribe or dispense medicines. However, CCA supports reforms that make medicines information more complete, accessible and useful to treating clinicians, provided this is implemented in a way that protects privacy, reduces stigma and avoids unnecessary administrative burden.
15. Would these requirements make it more likely for you to check My Health Record prior to prescribing/dispensing?	**No.** Not applicable. CCA does not prescribe or dispense medicines. However, if My Health Record becomes a more complete and reliable source of medicines information, it may become more useful to clinicians. This will depend on whether information is timely, accurate, easy to find, integrated with workflow and not duplicated across multiple systems.
16. Are there any other types of health information that you think should be required to be shared to My Health Record by healthcare providers?	**No.** CCA's primary focus is medicines information. Government should prioritise accurate, timely and interoperable medicines data before expanding mandatory sharing requirements. Any future expansion should be assessed against clear criteria, including clinical safety benefit, privacy risk, consumer understanding, technical feasibility and administrative burden.

17. Is there anything else you would like to tell us that has not been covered in this consultation?	**Yes.** CCA supports the policy intent of improving medicines safety, continuity of care and visibility of medicines information across the health system. However, this reform should not be implemented in a fragmented manner. Government should use this opportunity to consider the broader medicines information architecture and ensure reforms across My Health Record, real-time prescription monitoring, the National Prescription Delivery Service and the proposed National Medicines Record are aligned. Implementation should be nationally consistent, technically practical, low burden for clinicians, clear for consumers and sensitive to stigma. This is particularly important for medicinal cannabis patients, who may have legitimate concerns about privacy, discrimination and how their health information may be interpreted by future treating practitioners.