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SUBMISSION

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

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Asthma Australia welcomes the opportunity to comment on the consultation paper *Online prescribing services: Sharing medicines-related information to My Health Record by Default* from the Department of Health, Disability and Ageing and the Australian Digital Health Agency.

Improving timely access to information about current medicine use for individuals and healthcare providers is critical to support holistic and safe patient care. People living with chronic diseases like asthma often rely on a suite of medicines to effectively manage their symptoms at home. As such, Asthma Australia supports Sharing by Default to My Health Record for all prescription medicines involved in asthma care as well as specific pharmacist-only medicines.

In response to the consultation paper, Asthma Australia has made the following recommendations:

1. For mandatory sharing of information about the prescribing and dispensing of pharmacist-only medicines involved in asthma care, like short-acting beta$_2$ agonist (SABA) relievers to My Health Record. This is because of the strong link between SABA inhaler overuse and increased asthma morbidity and mortality.
2. For stronger regulation of oral corticosteroid (OCS) medicines used to manage severe asthma flare ups, following an asthma attack, or as part of routine asthma management in some people with severe asthma. While this medication is highly effective, even small lifetime cumulative doses of OCS have well-known serious side effects and long-term adverse health outcomes for patients.
3. For mandatory sharing of 'event summary' information when prescribing asthma medications, to accurately record a patient's asthma symptoms in parallel with medication use in alignment with clinical guidelines to support best-practice asthma care.
4. That Government considers embedding My Health Record checks directly into prescribing and dispensing software workflows to support point-of-care clinical decision making, with automated prompts or flags for contraindicated medicines, therapeutic duplication, or medication use patterns indicating poor disease control and risk.

THE IMPACT OF ASTHMA

Asthma affects 2.8 million people and costed the health system $1.28 billion in 2023-24[1,2,3]. It is the leading cause of disease burden among children aged 1-9 years and contributes to more than 31,000 hospitalisations annually, almost half involving those under 15[4,5,6]. Evidence from the Australian Institute of Health and Welfare (AIHW) shows up to 90 per cent of asthma-related hospitalisations could be prevented through accessible, high-quality primary health care and effective community-based prevention[6,7]. In 2024, 478 people died from asthma[8].

Despite being a manageable condition, asthma outcomes remain variable. Clinical guideline adherence is inconsistent, asthma health literacy is low and many Australians, particularly First Nations peoples, culturally and linguistically diverse communities, and those in rural and remote areas, continue to face inequitable access to asthma care. Consequently, the rates of hospitalisation from asthma and asthma mortality are substantially higher in Aboriginal and Torres Strait Islander people, people living in Australia's lowest socioeconomic areas and rural and remote communities[3].

In June 2026, a new report showed a significant worsening of key asthma indicators in Australian adults with asthma between 2012 and 2021, including poor asthma control and urgent healthcare utilisation[9]. Poor asthma control was widely attributed to suboptimal medicine use to manage asthma symptoms and flare ups, with only 13 per cent of participants using best-practice anti-inflammatory reliever treatments. Through better use of asthma medicines and adherence to clinical guidelines, there is scope to greatly improve asthma outcomes across and reduce preventable morbidity.

A STEPPED APPROACH TO ASTHMA CARE

In Australia, evidence-based clinical guidelines for the diagnosis and management of asthma are available in the National Asthma Handbook (the Handbook). The Handbook uses a stepped approach to asthma management by slowly increasing the dose and number of medications, with the goal of achieving good asthma control and fewer exacerbations while minimising side effects[10]. Best practice asthma care requires full transparency of the type and dose of medication a person needs to achieve symptom control, in addition to a broader assessment of medication adherence, asthma device technique (i.e., inhalers and spacers), and exposure to asthma triggers.

Asthma Australia highlights the description of asthma medications below is non-exhaustive, demonstrating the complexity of medication regimes for some people with asthma. In addition, overuse of some asthma medications, including short-acting beta$_2$ agonists (SABA) and oral corticosteroids have potential to cause significant harm or contribute to poorer asthma outcomes, including increased mortality from asthma. Polypharmacy in people with asthma is also common due to the complexity of asthma treatment plans in addition to medications associated with common comorbidities (antidepressants and pain management). It is crucial information about all medicines prescribed or dispensed to people with asthma is available to the health professionals involved in a person's asthma care to ensure their symptoms can be managed safely and effectively.

First line asthma treatment and updated clinical guidelines

In 2025, updates to clinical treatment guidelines in the Handbook marked a significant change in the recommended medications for first line asthma treatment. Anti-inflammatory relievers (including inhaled corticosteroid/rapid-onset long-acting beta agonist medicines (ICS/LABA) like budesonide-

formoterol) are now advised to treat flare ups of asthma symptoms, in place of short-acting beta$_2$ agonists (SABA; the "blue puffer") for all adults and adolescents.

While SABA medications are effective for opening the airways to relieve asthma flare ups, they do not treat the underlying inflammation responsible for asthma symptoms and cannot support improved asthma control. There is extensive evidence SABA inhaler overuse (more than three 200-dose canisters per year) is associated with increased risk of severe asthma exacerbation, while dispensing 12 or more canisters a year (possibly even less) is linked to increased asthma mortality[11,12,13,14].

SABA inhalers are currently available as Schedule 3/pharmacist only medicines in Australia and can be accessed by people with asthma with or without a prescription. Asthma Australia emphasises while SABA medications themselves are not generally harmful to use, SABA inhaler overuse by people with asthma has significant health consequences and poorer disease outcomes. Greater visibility between healthcare settings on when SABA medicines are both prescribed and dispensed to people with asthma would support improved asthma management and reduce preventable health service utilisation after severe asthma exacerbations.

Management of severe asthma

When increasing the dose of anti-inflammatory based therapies is insufficient to achieve asthma control, this is considered difficult-to-treat asthma and requires specialist referral and in-depth assessment. Patients can commence long-acting muscarinic antagonist (LAMA) medicines in combination with anti-inflammatory based (ICS/LABA) medicines, which is known as "triple therapy", as three different medicines are working together to achieve asthma control.

Treatment with biologics (monoclonal antibodies) is available for some people with severe asthma. The type of biological medicine available for use is tailored to the patient's specific asthma type and immune cell profile. Biological medicines are subsidised by the PBS under the *National Health Act 1953*, section 100 for people with severe asthma[15]. Once monoclonal antibody therapy is initiated by a specialist, doses can be administered (by injection) in primary care or self-administered by the patient.

Oral corticosteroids (OCS) are used to manage severe asthma flare ups, following an asthma attack, or as part of routine asthma management in some people with severe asthma. While this medication is highly effective in managing both acute flares and chronic asthma symptoms, even small lifetime cumulative doses of OCS have well-known serious side effects and long-term adverse health outcomes for patients[16]. This includes decreased bone density, behavioural changes, weight gain, dental issues and more. Improved OCS stewardship is required to reduce harm from their overuse, while maintaining their availability for people with asthma when it is needed.

Managing asthma comorbidities

Many people living with asthma experience comorbidities, which increases the complexity of their health needs and medication use. In 2022, 1.8 million (65 per cent) of people with asthma also had one or more chronic health conditions. The top three comorbidities for asthma were mental and behavioural conditions (41 per cent), back problems (25 per cent), and arthritis (23 per cent)[1].

The psychological burden of living with asthma is clear, with evidence suggesting antidepressant use is significantly higher in people with asthma than the background population[17]. Pain associated with asthma comorbidities means patients have a higher likelihood of being prescribed opioid medications[18], with opioid misuse in people with asthma linked to poorer asthma outcomes[19].

Polypharmacy is common in older people with asthma due to frequent comorbidities, with asthma complicating the treatment of other chronic health conditions[20].

Accurate, available and transparent records of medications prescribed and dispensed to people with asthma is important to safely and effectively manage asthma in parallel with other health conditions.

CONSULTATION QUESTIONS

What matters most to you when using online prescribing services, or what do you think matters most to people who use them?

The consultation paper highlights people in rural and remote communities are likely to benefit from online prescribing services, where there are more barriers to attending face-to-face health services. This would also apply to people with asthma. Asthma outcomes worsen with increasing remoteness, and this is likely associated with less access to health services.

People with asthma are comfortable using digital health services, with a research report from the Australian Digital Health Agency highlighted people with asthma and COPD are more likely to use electronic prescriptions than people without these conditions[21].

Online prescribing services advertising to people with asthma consistently highlight the convenience and safety of telehealth asthma reviews. This includes the use of online services to reduce the risk exposure to respiratory viruses, which are the biggest trigger for asthma flare ups, compared to face-to-face services. Being 24/7, online services emphasise the convenience of telehealth asthma care in their advertising, with a focus on supporting families as they juggle school and work commitments. With asthma being the leading childhood disease burden in ages 1-9 years, there is scope for these services to be highly utilised by people with asthma and their families where other health services are not available.

Online prescribing services can deliver a large portion of asthma care, including the assessment of medication adherence, spacer technique, the development of Asthma Action Plans, and the prescribing of asthma medications. People with mild-moderate or uncomplicated asthma may find these services are adequate for managing their illness.

What medicines information should be required to be shared to My Health Record to support safer and more coordinated care?

Asthma Australia broadly supports the definition *for Medicines-related information (prescribing and dispensing information)* included on page 6 of the consultation paper, with one exception.

The absence of a mandatory requirement to share information about over-the-counter medications, including pharmacist-only medications is concerning for Asthma Australia given the significant issues associated with SABA inhaler overuse and poor asthma outcomes. While it may not be feasible for pharmacists to share every pharmacist-only medicine to My Health Record, Asthma Australia would like the dispensing of SABA medicines to be recorded on a patient's My Health Record. This should occur when SABA medicines are accessed using a prescription or over the counter.

Should different requirements such as stronger safeguards apply for higher risk medicines (for example opioid pain or stimulant medication)?

Asthma Australia believes stronger safeguards should be applied to OCS medicines. Harmful side effects from this medicine are cumulative over a person's lifetime, meaning even minor overuse of OCS on several occasions can cause significant harm. An example of this occurs when OCS is

prescribed to manage an asthma flare up, but it is prescribed and dispensed according to the medication pack size rather than the volume of medicine is needed for treatment. Due to this oversupply, the patient can self-medicate during future symptom occurrences without medical intervention. Safeguards to improve the monitoring of OCS use, or to restrict the volume of OCS given to a patient at any one time would improve OCS stewardship and improve patient safety.

Are there medicines that should be exempt or treated differently due to their potential sensitivity or risk?

In addition to the risk associated with SABA inhaler and OCS overuse, biological therapies for asthma are associated with the highest risk, noting they are already part of the Highly Specialised Drugs Program. Given the current restrictions around access to biological therapies, it seems unlikely online prescribers would have authority to prescribe these to people with asthma, even as a repeat prescription.

Are the requirements for online prescribing services to share medicines related information to My Health Record clear, including who it applies to, what information would be shared and how it should be shared?

The consultation paper is clear on the *proposed scope and definitions* included on pages 5 and 6. Asthma Australia has already outlined the risks associated with excluding some over-the-counter medicines, like SABA inhalers, given the risks of morbidity and mortality from asthma with their overuse.

Asthma management uses a stepped approach to the dose and number of medications prescribed to a patient, with the goal of achieving good asthma control and fewer exacerbations while minimising side effects. As such, any information from a patient about their asthma control, current symptoms, number of exacerbations, and whether they have sought emergency care is critical to support appropriate prescribing of asthma medications. For best practice asthma care, this information should be Shared by Default to My Health Record whenever a prescription for asthma medications is initiated or issued as a repeat.

The *proposed scope and definitions* in the consultation paper outlines existing digital health systems and tools available to support the sharing of medicines information, including event summaries. As written, the sharing of event summaries by healthcare providers appears to be optional. Mandatory sharing of event summaries with the prescribing of all asthma medications, especially those associated with harm like OCS is recommended.

Are there any online prescribing services that should be excluded from the new requirements to share to My Health Record (see definitions on pages 5 and 6), and if so, why?

Asthma Australia is not aware of any prescribing services that should be excluded.

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?

Asthma Australia understands patients can choose to hide or delete records shared to My Health Record at present, or request they not be uploaded by their healthcare provider.

For medicines with the potential to cause harm, like OCS, the ability to hide information about whether they have been prescribed or dispensed from healthcare providers in My Health Record may increase their risk while undermining OCS stewardship. Asthma Australia encourages the

Department of Health, Disability and Ageing to explore whether a person can exercise their right to privacy by hiding the details of a prescribed medication, while not removing the existence of the medication completely from My Health Record. For example, the details of the medicine may be hidden, but the patient's usual doctor may still see a medicine (no name, dose, or other identifying information) was prescribed or dispensed to a patient. This could then trigger a conversation with the patient to learn more information about the details of the medications they were prescribed and why.

What should Government consider to support healthcare providers to check medicines information in My Health Record, before prescribing or dispensing?

Availability of medicines information in My Health Record does not guarantee it will be consistently viewed or acted upon. Government should consider embedding My Health Record checks directly into prescribing and dispensing software workflows, rather than requiring a separate log-in, particularly given the time-pressured and often asynchronous nature of online prescribing consultations.

For chronic conditions such as asthma, passive access to a medicines list is insufficient. Government should consider mandating or incentivising point-of-care clinical decision support, with automated prompts or flags for contraindicated medicines, therapeutic duplication, or medication use patterns indicating poor disease control.

Consideration should also be given to supporting structured capture of prescribing rationale, given that clinical context is often as important as the medicine itself for conditions involving step-up or step-down therapy. Consistent use of Individual Healthcare Identifiers should be prioritised to ensure records underpinning these checks are reliably complete.

Targeted, profession-endorsed guidance should clarify expectations for reviewing My Health Record in online and asynchronous prescribing contexts, including where a prescriber has no pre-existing relationship with the patient.

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

Recent reporting highlights while Australian healthcare providers broadly support Sharing by Default reforms, software vendors remain the biggest obstacle to its successful rollout. This is reinforced by the Australian Medical Association's *digital interoperability research paper* (January 2026), which identifies low uptake of My Health Record among medical specialties and ongoing incompatibilities between My Health Record and health IT software. While Asthma Australia does not propose a specific technical solution resolving these interoperability challenges and improving the availability of medicines information is essential to supporting coordinated, safe asthma management across healthcare providers.

Beyond software readiness, Government should consider the following additional impacts and challenges:

- Variable system capability: As the background paper notes, not all clinical software supports automated uploads, and "do not upload" settings can prevent sharing even where connectivity exists. Reform should account for the pace at which vendors, particularly those serving smaller practices and online prescribing services, can achieve compliant integration.
- Workforce and workflow burden: Introducing new checking obligations without adequate decision-support design risks increasing clinical workload and contributing to alert fatigue, potentially reducing the effectiveness of safety prompts over time.

- Transitional and compliance arrangements: Given the paper's acknowledgment that compliance mechanisms for online prescribing services are still being considered, Government should ensure adequate lead time, technical support and guidance before compliance measures or penalties apply.
- Consistency across jurisdictions: Preserved privacy laws in the ACT, NSW and Queensland create differing consent requirements for uploads. This variability adds complexity for online prescribing services operating nationally and should be clearly addressed in implementation guidance.
- Equity of access: Consideration should be given to people who face barriers to digital health engagement, to ensure reforms improve, rather than inadvertently disadvantage, continuity of care for these groups.

Addressing these challenges will be critical to ensuring the reform delivers genuine improvements in medicines safety for people managing chronic conditions such as asthma.

ABOUT ASTHMA AUSTRALIA

Asthma Australia is the nation's peak body representing nearly 2.8 million Australians living with asthma. Our work is grounded in evidence and informed by the lived experience of people with asthma. Our programs reflect a commitment to outcomes-focused, equity-driven reform, integrating community insight and clinical expertise to strengthen person centred asthma care.

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