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SUBMISSION

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AMA submission to consultation on modernising referral pathways – additional comments

By email: specialistaffordability@health.gov.au

Introduction

The AMA appreciates the opportunity to contribute to this Department of Health, Disability and Ageing consultation on referral pathways between general practitioners (GPs) and non-GP specialists, and from one non-GP specialist (or consultant physician) to another.

For the purposes of this submission only, the AMA will follow the Department's lead in using the term 'non-GP specialist' to refer to both non-GP specialists and consultant physicians unless otherwise indicated, given that under the *Health Insurance Act 1973*, there is no distinction between these groups in relation to referral arrangements.

Rather than responding to the extensive survey questions directed to individuals in the consultation paper, this submission initially provides comment on the Department's proposed approach to 'modernising referral pathways' as outlined on pp. 5-7 of the consultation paper. It then provides further comment on a referral issue the Department does not raise in the consultation paper, but which warrants attention.

As an opening observation, the AMA's view is that the current referral framework, while imperfect, largely supports coordinated and clinically appropriate care. Targeted reform — particularly reform to National Health Reform Agreement rules that mean public emergency department referrals are not valid for private specialist Medicare billing — could improve access to care.

The AMA understands that consumers have expressed concerns about the need to 'modernise' the referral process to reduce out-of-pocket costs and increase the accessibility of care. However, broad extension of default referral validity periods or removal of GP reconnection points would fragment care and place patient safety and quality of care at risk. While some consumers may wish to access all aspects of the health system without a gatekeeper, the reality is that if government provides this access, there are likely to be unintended consequences that will harm patients.

Unfortunately, many consumers do not understand the value of continuity of care to their health. The move to transactional healthcare interactions, such as getting a referral or medical certificate online

from a non-medical practitioner, has changed consumer behaviour and expectations and is promoting 'fast-food' healthcare that has higher overall costs and poorer healthcare outcomes.

Referrals are not an administrative transaction that stand in the way of access and efficiency, as some of the wording in the consultation paper implies. They are an essential clinical safety mechanism that enables shared decision-making between all members of the clinical care team and the patient. They create better outcomes for patients, and by extension, better outcomes for the whole health system.

Coordinated GP oversight remains essential, particularly for patients with multi-morbidity or complex chronic diseases, who may be on multiple medications requiring regular adjustment, and often have multiple non-GP specialists involved in their care. Referrals are a way of communicating a wide range of information, including changes in a patient's health and medications, and who is currently (or has been) involved in their care. Referral frameworks must, therefore, continue to support coordinated GP oversight of patient care.

If any reforms to referral pathways are made, they must be supported by government investment in digital interoperability, and secure messaging reliability: without digital integration, longer referral validity risks weakening communication between GP and non-GP specialists.

The Department's proposed approach to medical referral reforms

'More informed consumers and clinicians'

Medical costs finder website

The AMA has supported the Department's upgrades to the Medical Costs Finder website that will provide consumers and GPs with more detailed information about the costs of medical services and individual non-GP specialist fees.

Mandating standard information about how referrals operate on all referrals

The AMA acknowledges that many patients are unfamiliar with the rules around referrals.

While most GPs will explain to patients that the naming of a specific practitioner in a referral does not prevent the patient from seeing a different non-GP specialist in the same field if they wish to, patients who are unwell may forget this if the information is provided only verbally at the consult with the GP.

Given this, the AMA would not object to a requirement that all referrals provide standard information on how referrals operate — for example, that a patient can take a referral to a non-GP specialist in the same field who is not named on the referral, the period during which the referral is valid, and where to get further information.

Mandating patients get a hard or soft copy of their referral and non-GP specialist reports

The AMA supports the view that patients should be offered a hard or soft copy of their referral (via email or upload to My Health Record).

Most AMA members provide — or offer to provide — such a copy already. However, it is important to note that many patients, when offered, refuse a copy, particularly when it is a regular re-referral, and that it is not currently possible for many GPs and non-GP specialists to upload a referral to My Health Record using their clinical software.

Before deciding to mandate uploads of referrals or reports to My Health Record, further consultation with the profession would be required regarding the administrative impact as well as the technical capability of the system to allow that. The AMA reiterates that sharing of health information, with patient consent, should happen without additional administrative burden for practitioners.

Referral validity periods

Increase default validity period of GP to non-GP specialist referrals from twelve months to a longer fixed period or an indefinite period

The AMA recognises that for some patients, the effective treatment of chronic conditions may require ongoing non-GP specialist care that continues beyond 12 months, in which case a patient with a 12-month referral will need to seek another referral from their GP.

The AMA also acknowledges the Consumer Health Forum 2025 Budget Submission, which suggests that consumers may be frustrated both by the need to obtain a new referral and the potential cost involved if their GP does not bulk bill. Nevertheless, the AMA notes the increased proportion of GPs who bulk-bill, and the increased availability of telehealth, which significantly reduces inconvenience.

However, the AMA believes that the default validity of GP referrals to non-GP specialists should remain at twelve months. Exchange of information between GPs and non-GP specialists on at least a yearly basis is essential for patient safety. Details of the patient's medication, medical and family history and allergies must be kept up to date, along with any changes to the patient's clinical risk, so the referral recipient can prescribe and treat safely.

Referral renewals also serve the important function of

- confirming details of the patient's current GP
- reducing the likelihood referees will send correspondence to practitioners who have moved, retired or passed away
- mitigating communication failures where patients have changed GPs.

If the government was to increase the default validity period of GP to non-GP specialist referrals, against the AMA's recommendation, non-GP specialists would not agree to any new rules that would mandate them to notify a patient's GP/referring medical practitioner when there is a change in treatment or medication.

This kind of communication is a core professional responsibility of non-GP specialists that most take very seriously, in line with the AMA's position statement 10 Minimum Standards for Communication between Health Services and General Practitioners and other Treating Doctors. That document sets out the information that should be included in referrals. It also states that treating non-GP specialists should inform a patient's GP and other treating doctors of:

- any unplanned inpatient admissions, discharges, attendances at an emergency department, or sentinel events within 24 hours
- the outcome (findings and treatment plan) of an initial specialist consultation, changes in health status or medication at a specialist outpatient service, or discharge from a specialist outpatient clinic within 7 days.

However, as discussed in the AMA's January 2026 Digital interoperability report, doctors currently face numerous operational challenges related to secure messaging systems, particularly in relation to

interoperability. For example, if a non-GP specialist uses HealthLink, confirmation of receipt at the receiving practice is not always possible. In addition, private practice software lacks meaningful interoperability with My Health Record and secure messaging platforms. Without mandated integration across systems, digital referral reform will not work and may even slow adoption.

Before introducing compliance-based safeguards, such as rules around when to notify the treating GP of a change of treatment or medication, the government should invest in digital integration and reliable receipt mechanisms — specifically, a nationally consistent and easily accessed secure email service that integrates with all software vendors, as outlined in the AMA position statements 10 Minimum Standards for Advancing Digital Health in General Practice, and System Interoperability in Healthcare.

Increase default validity period for non-GP specialist to non-GP specialist referrals to beyond three months

The AMA supports the current default referral validity period of three months for referrals between non-GP specialists, which is designed to ensure that GPs maintain their current care co-ordination role.

We also note that in 2020, the MBS Review Taskforce considered but rejected a proposal to extend the default validity period of these referrals from three months to six months, citing the need to preserve the central role of the GP in patient care coordination as the reason for its decision.

Extending the default validity period for these referrals would not meaningfully reduce specialist workload and would increase the risks of miscommunication already outlined.

Make the default GP to non-GP specialist referral validity period indefinite and remove the 9-month initial attendance rule

The Department cites evidence that for some non-GP specialists, there is confusion around:

- the definition of 'a single course of treatment'
- the 9-month attendance exception to the rules surrounding a single course of treatment[1]
- whether an initial attendance item can be claimed following the renewal of a referral.

It also cites evidence that where multiple initial attendance items are incorrectly claimed, this results in higher out-of-pocket costs for patients.

The Department also seeks the view of stakeholders on adopting a default indefinite referral validity period and removing the 9-month initial attendance rule. The Department suggests that by making the default referral period indefinite, confusion over appropriate billing would decline even if the 9-

[1] Other than for psychiatrists, the usual billing rule that is that if a course of non-GP specialist treatment continues across multiple renewed referrals, an initial attendance item cannot be claimed except for the very first consultation with the non-GP specialist. The one exception is where the referring practitioner considers a review of the patient's condition necessary, and the patient hasn't seen the treating non-GP specialist for 9 months or more. This results in the commencement of a new course of treatment, where the treating non-GP specialist *can* claim an initial attendance item.

month initial attendance rule was kept, because it would apply less frequently under a default indefinite referral regime.

Given this, the Department also seeks views on whether the 9-month initial attendance rule would be necessary if an indefinite default referral validity period was implemented, and whether there is a clinical need for patients who have not seen their non-GP specialist for 9 months to be billed an initial MBS attendance item.

However, as discussed earlier in this submission, the AMA does not support moving to default indefinite referral regime.

The rule allowing billing of an initial attendance item if more than nine months have elapsed and the referring GP considers review clinically necessary could potentially be reconsidered. However, the longstanding principle that patients discharged and not seen for 12 months are considered new patients must remain in place. Clinical risk frequently changes over that timeframe, and a genuine reassessment is frequently required.

With respect to billing errors, the billing rules are generally conceptually clear to specialists, but frequently misunderstood by patients, and this can be operationally complex for administrative staff, who require regular training to apply billing rules correctly. For example, patients often request 'review' appointments for an entirely new condition, and a returning patient may feel that they are not a 'new' patient, even when they present for an entirely new condition.

Any concerns the Department has about billing compliance should be addressed through provision of clearer information and education about relevant rules to patients, and to any medical practitioners who are repeatedly making the kinds of billing errors with which the Department is concerned.

Allowing second opinions under the same GP referral

The Department suggests that the inability of patients to take their referral to a new non-GP specialist using the same referral after another non-GP specialist has already provided a consultation is a problem for consumers who want to seek a second opinion.

The Department suggests modifying relevant legislation to explicitly permit:

- continuation of treatment under a different practitioner on the same referral
- both the first practitioner and the second practitioner to bill an initial attendance item in this circumstance.

The AMA does not support this change. While allowing patients to seek multiple non-GP specialist opinions under the same referral may reduce administrative friction and costs to patients, it also carries significant risks:

- increased 'doctor shopping' driven by waiting times rather than clinical appropriateness
- facilitation of intervention-seeking behaviour in procedural specialties.

For example, in surgical disciplines, it is not uncommon for a specialist to recommend against intervention in a patient's best interests. A system that makes it easier to seek multiple opinions without renewed GP engagement may unintentionally favour more intervention-oriented care.

While patient autonomy is fundamental, safeguards that preserve GP guidance and care co-ordination are also essential.

Comment on an additional issue not raised in the consultation paper

Referrals issued by public hospital emergency departments should be valid for private specialist Medicare billing

To modernise the referral process, the AMA would like to see a change in the current rule that referrals issued by public hospital emergency departments are not valid for private specialist Medicare billing.

In practice, this rule creates delays in care, patient frustration and duplication of consultations.

Patients discharged from public emergency departments are often advised to seek private specialist review. When informed that they must first obtain a GP referral to meet Medicare requirements, they frequently perceive this as unnecessary duplication.

In metropolitan areas, many patients can access a GP relatively easily, including via telehealth models. In rural and regional settings, however, GP access may be limited, and this requirement can create unintended access barriers and inequitable delays in access to care.

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