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RACP submission
Modernising referral pathways

March 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 23,200 physicians and 8,700 trainee physicians across Australia and Aotearoa New Zealand.

The RACP represents a broad range of medical specialties, including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine.

Beyond the drive for medical excellence, the RACP is committed to developing healthcare policies which bring vital improvements to the well-being of patients, the medical profession and the community.

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



Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide a submission in response to the Department of Health, Disability and Ageing's Consultation Paper: Modernising Referral Pathways. Representing over 30,000 physicians and paediatricians across Australia and Aotearoa New Zealand who rely daily on effective, well-designed referral systems to deliver high-quality, patient-centred care, **the RACP is uniquely positioned to comment on the necessity of seamless GP to specialist and specialist-to-specialist pathways and the modernisation of referral validity to meet contemporary clinical needs.**

Referral pathways are not merely administrative mechanisms. They are a cornerstone of coordinated, safe and efficient healthcare delivery. **The RACP strongly supports efforts to modernise referral arrangements and welcomes the Department's recognition that current rules may not adequately reflect the nuances of contemporary clinical practice, particularly in the management of chronic and complex disease.**

Any healthcare reform must account for the timely and effective provision of services by physicians to address the growing burden of chronic disease among older persons and children.¹ **Our recommendations focus on reducing administrative burden, aligning referral structures with value-based care principles, and enhancing digital interoperability to ensure that referral pathways do not impede patient access or continuity of care.**

Recommendations

1. **Fund comprehensive MBS compliance and claiming education for physicians and other specialists**, developed in coordination with medical colleges, including enhanced AskMBS tools with decision support resources, case studies and e-learning modules, and point-of-claim software to reduce misunderstandings about billing entitlements.
2. **Standardised referral information should be system-generated to avoid additional administrative burden on referring clinicians.** Patients should receive copies of referrals as a default, consistent with My Health Record sharing reforms.
3. **Default validity period for GP-to-physician referrals should be extended to indefinite**, with referring practitioners able to specify a time-limited period where clinically appropriate.
4. **Remove the three-month limit on specialist-to-specialist referrals and allow them to be extended to what is clinically appropriate in the circumstances**
5. Align referral arrangements with value-based care principles, **ensuring that the definition of a "single course of treatment" does not limit physicians from providing clinically necessary, longitudinal care to complex patients, with scope to use appropriate MBS items reflective of patient care needs.**

¹ Royal Australasian College of Physicians. Physicians and paediatricians: essential to multidisciplinary care. RACP. 2024. [racc-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf](#)

6. Legislation should be amended to **permit initiation of treatment with a different specialist practicing the same discipline under an existing referral**, with the second specialist entitled to bill an initial attendance item. This should be accompanied by requirements for appropriate clinical information transfer between practitioners.
7. **Implement the Strengthening Medicare recommendation to “modernise My Health Record to significantly increase the health information available to individuals and their health care professionals”.**
8. **Fund the development and expansion of new collaborative models of care, including eConsult platforms and shared care arrangements**, to reduce unnecessary formal referral episodes, allow earlier access to necessary specialist advice, reduce waiting times to access care and support enhanced specialist-GP collaboration, with **MBS item changes to support these models**.

The importance of specialist referral pathways

Medical referrals serve as a structural foundation for coordinated specialist care in Australia. For physicians, referrals fulfil several distinct clinical functions:

- Enabling diagnostic opinion and specialist assessment for conditions beyond the scope of primary care.
- Providing targeted management advice to support coordinating practitioners, particularly GPs.
- Facilitating timely transfer of clinical responsibility where specialist oversight is required; and
- Enabling access to procedural interventions requiring specialist training and infrastructure.

Equally important are the system-wide implications of how referrals operate. **Well-designed referral pathways support shared care models between GPs, specialists and allied health practitioners, help avoid fragmentation of care across multiple providers, and function as a safety net to ensure patients with complex needs receive appropriately coordinated oversight.**

Health care reform – including comprehensive primary health care – must consider timely and effective specialist care. **An ageing population, rising chronic and complex conditions, and growing pressures on children and carers all require stronger physician involvement, particularly through innovative models to support earlier access by GPs to physician advice.** Better integration between physicians, GPs and allied health practitioners is essential to deliver coordinated, patient-centred and cost-effective care.²

The RACP has identified that the process of referral from GP to physician is neither efficient nor satisfactory to patients and practitioners, with point-to-point referrals often lacking the richness of two-way clinical discussion.³

² Royal Australasian College of Physicians. Physicians and paediatricians: essential to multidisciplinary care. RACP. 2024. [racc-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf](#)

³ Royal Australasian College of Physicians. Physicians and paediatricians: essential to multidisciplinary care. RACP. 2024. [racc-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf](#)

Current referral arrangements continue to present significant barriers, including limited patient and clinician understanding, validity periods ill-suited to managing chronic conditions, and inadequate digital interoperability across care settings. Coordinated reform in each of these areas is necessary and timely.

Understanding referral pathways

Many patients are unaware of fundamental aspects of referral arrangements, especially the implications of not having a referral and the referral validity periods, as well as their right to use a referral with any practitioner in the same discipline as the named specialist.

From a clinician perspective, RACP members have similarly reported confusion regarding Medicare Benefits Schedule (MBS) referral rules, validity periods and renewal requirements. There is confusion related to cross-setting referrals, with some clinicians unaware of considerations that need to be made when referring to different specialty types.

Many RACP members felt that essential information for effectively triaging and treating the patient can be missing. Information areas, in order of frequency of items missed, include relevant diagnostic/test results, specific clinical question/reason for referral, current medications and dosages, and the patient's medical history.

The RACP supports the following proposed measures to improve understanding and transparency:

- Mandating that referrals contain standardised information about how they operate, including links to the Medical Costs Finder (MCF). This measure should not impose additional administrative burden on referring practitioners. Any standardised disclaimer should be system-generated rather than requiring manual input.
- Providing patients with copies of their referrals as a default. Access to referral documents supports patient agency, enables informed financial decision-making and limits risk of referrals not making it to the physician. This aligns with My Health Record reforms.

The RACP continues to call for the development of enhanced compliance and claiming tools for physicians.

The RACP supports MCF enhancements in principle. However, it is important that any fee transparency framework appropriately contextualises the complexity of physician care.

Physicians spend a lot of time caring for complex patients, including considerable non-face-to-face time. It is important to ensure practitioners are not discouraged from treating complex patients because of regulatory changes which make providing that care even more difficult.

Recommendations to improved understanding of referral pathways

Recommendation 1: The Government should fund comprehensive MBS compliance and claiming education for physicians and specialists, developed in coordination with medical colleges, including enhanced AskMBS tools with decision support resources, case studies and e-learning modules, and point-of-claim software to reduce misunderstandings about billing entitlements. Advice given by AskMBS should also be able to be relied on for claims, rather than limited to being general advice only.

Recommendation 2: Standardised referral information should be system-generated to avoid additional administrative burden on referring clinicians. Patients should receive copies of referrals as a default, consistent with My Health Record sharing reforms.

Referral validity periods

Australia's current referral validity periods – 12 months for GP-to-non-GP specialist referrals and three months for non-GP-specialist-to-non-GP-specialist referrals – were designed primarily for acute episodic illness. They are poorly suited to the management of chronic and complex conditions, which now represent the dominant burden of disease in Australia.

Many RACP members do not feel that the current default 12-month GP to specialist referral period meets the clinical needs of patients with chronic or complex conditions. There was strong support for indefinite referrals.

The RACP supports extending the default validity period for GP-to-specialist referrals beyond 12 months.

The RACP's preferred position is that indefinite referrals should be available where clinically appropriate, with practitioners able to specify an end date where a time-limited episode of care is anticipated.

An indefinite default validity period would significantly reduce the administrative burden of referral renewal for patients with stable, long-term conditions, and better suits the management of conditions requiring ongoing specialist involvement where the clinical need remains unchanged.

While an indefinite model offers significant potential advantages for many conditions, in supporting timely access to care and reducing unnecessary work, it would not be universally appropriate across all specialties and patients. In certain contexts, there may be risks that patients may stop or significantly reduce their visits to their GPs, treating their physician as their primary care provider. This would be inappropriate. In some cases, the current requirement for a referral renewal can serve as an important clinical checkpoint, ensuring the patient maintains a relationship with their GP for holistic care and sees their physician when appropriate.

While a 12-month period is often too short for stable patients, a move to a completely indefinite model may undermine the GP's essential role and increase the burden of patient load for physicians. It would be important to work with the RACP, RACGP, ACRRM and other key stakeholders to ensure an approach which balances timely and appropriate access to both physician and primary care.

If an indefinite default is adopted, the Consultation Paper identifies mandatory specialist notification to the referring GP upon changes in diagnosis, treatment or medication as one potential safeguard to preserve the GP's coordinating role. It also recognises that there should be concerted efforts to ensure that this does not unintentionally discourage patients from seeing their GP for their broader care needs. The RACP supports further consultation with members and relevant stakeholders on the design of appropriate safeguards and considers that any such requirements should avoid creating administrative burdens that simply substitute for the current inefficiency of referral expiry.

Introduction of default indefinite referrals must preserve the ability for physicians to access MBS items reflective of care provided. Given the variety, complexity and uncertain clinical courses of conditions seen by physicians, the level of care reflected in an initial MBS consultation item may be required at various times whilst a patient is under the care of a physician.

On the question of specialist-to-specialist referral validity periods, a three-month period is often inadequate, given the complexities of the conditions involved and challenges in accessing specialist care during such a relatively short period, particularly in the context of significant workforce shortages and significant waiting lists across different specialties and regions. The growing prevalence of multi-specialist management, particularly in areas such as oncology, complex chronic disease and paediatric care warrant a less restrictive approach.

The RACP supports removing the three-month limit on specialist-to-specialist referrals and allowing them to be extended to what is clinically appropriate in the circumstances, whether that be 6 months, 12 months or indefinite.

Recommendations to address referral validity concerns

Recommendation 3: The default validity period for GP-to- specialist referrals should be extended to indefinite, with referring practitioners able to specify a time-limited period where clinically appropriate.

Recommendation 4: Remove the three-month limit on specialist-to-specialist referrals and allow them to be extended to what is clinically appropriate in the circumstances

Work will need to be done involving the RACP, RACGP and other stakeholders on how to ensure the patients GP's remains involved as needed in the patient's care, whether through copies of referrals being provided to the GP, or otherwise.

Single course of treatment and billing

The RACP believes that moving to an indefinite referral model may naturally reduce confusion regarding whether to bill an initial or subsequent item.

Changes must recognise the complexity of care involved, including the 'cognitive service' provision of physicians, which often involves high-complexity work even in follow-up consultations.⁴

As set out above, given the variety, complexity and uncertain clinical courses of conditions **seen by physicians, the level of care reflected in an initial MBS consultation item may be required at various times whilst a patient is under the care of a physician, whether following a GP to specialist referral or a specialist-to-specialist referral. Need for repeat use of an initial attendance item should be based on clinical need, not merely provision of a referral.**

Recommendations to address single course of treatment concerns

Recommendation 5: Align referral arrangements with value-based care principles, ensuring that the definition of a "single course of treatment" does not limit physicians for providing necessary, longitudinal care to complex patients, with scope to use appropriate MBS items reflective of patient care needs

Second opinions and change of practitioner

The RACP supports reforms to enable patients to seek a second opinion or change practitioner under an existing referral without requiring a new referral. Current rules create unnecessary barriers to patient choice and can deter patients from seeking second opinions due to the inconvenience and cost of returning to their GP.

The RACP notes the following considerations in the design of this reform:

⁴ Royal Australasian College of Physicians. Submission to Report from the Specialist and Consultant Physician Consultation Clinical Committee of the MBS Review Taskforce . RACP. 2019. [racp-submission-to-the-report-from-the-specialist-and-consultant-physician-consultation-clinical-committee-of-the-mbs-review-taskforce.pdf](#)

- Allowing a second specialist to bill an initial attendance item when first seeing the patient under an existing referral is appropriate, as that consultation will typically require equivalent effort to a new consultation.
- Clear communication is needed to manage patient expectations regarding wait times and access when switching providers. Clear communication with GPs is also necessary to ensure continuity of care is facilitated.
- Care should be taken to avoid duplication of investigations or procedures. Where a patient transitions between specialists under the same referral, appropriate information transfer should be required.
- In rural, regional and remote settings, patients may have limited choice of specialist providers. Reform should be complemented by investment in alternative consultation options, such as telehealth and eConsult models, to ensure equitable access for patients in these communities.
- Incorporate reforms that protect against doctor shopping. This may include making referrals specialty specific.

Recommendations to second opinion and change of practitioner pathways

Recommendation 6: Legislation should be amended to permit initiation of treatment with a different non-GP-specialist practicing the same specialty under an existing referral, with the second specialist entitled to bill an initial attendance item. This should be accompanied by requirements for appropriate clinical information transfer between practitioners.

Digital modernisation and interoperability

Digital reform is essential to the successful implementation of the changes proposed in this Consultation Paper.

Extended and indefinite referral periods will require robust digital systems to ensure that practitioners are able to transfer care efficiently and remain appropriately informed of their patients' specialist care.

The RACP has consistently advocated for investment in digital infrastructure that supports all parts of the healthcare system equitably.

Current incentive structures and software platforms for physicians in private and public settings lag significantly behind those available to general practice. A large portion of RACP members identified the lack of software interoperability and workflow and administrative costs as primary barriers to digitally integrated practice.

If the Government is to proceed with extending the Sharing by Default legislation to GPs, physicians and other specialists the following must be considered to effectively implement changes:

- Fund physician-specific interoperability: provide incentives and software platforms for physicians, consistent with support previously provided to General Practice.
- Streamline processes: ensure that uploading to My Health Record reduces, rather than increases, administrative burdens.
- Improve data quality: focus on the usefulness of clinical information shared between providers to support better-informed decision-making.

The RACP also supports the development and funding of collaborative **models of care that reduce reliance on linear point-to-point referrals**. To ensure these arrangements deliver genuine improvements in patient outcomes, they must be underpinned by clear clinical protocols, accountability structures, and outcome monitoring. These models must be supported by **innovative blended funding models** that

- provide funding support for GPs to easily seek advice from medical specialists
- break down the place of service delivery (public hospital versus private practice) funding barrier for patients with chronic conditions to ensure GPs and physicians can work collaboratively from the same care plan
- appropriately design and index Medicare rebates so they are sustainably aligned with inflation.

Examples of successful collaborative care models include:

- **eConsultant platforms** enable GPs to seek timely specialist advice without requiring formal referral or patient attendance. Mater Queensland eConsultant offers a 'Request for Advice' service to support GPs wanting access to specialist advice which provides early access to advice before a consultation with a specialist and can reduce the need for a specialist face-to-face outpatient consultation. A recent evaluation indicated that 82 percent of cases were able to avoid face-to-face visits⁵
- **Rural Geriatrician in the Practice program** - focused on delivering a patient centered shared care approach between the GP and geriatrician. A review found participants "were less likely to have planned reviews, actual reviews and emergency department presentations than patients who did not take part in the program"⁶
- **Strengthening Care for Children** involves placing a paediatrician within a general practice for weekly co-consultation sessions and monthly case discussions. An evaluation of the Strengthening Care for Children Project in Victoria involving 896 families revealed that it decreased referrals to private paediatricians after the intervention (from 34% to 20%) and emergency departments (from 19% to 12%).⁷
- **The RACP's [Model of Chronic Care Management](#)** – people with co-morbidities at an 'intermediate' level of care to make multidisciplinary team care more accessible and patient-centred.⁸

Details of a range of different models across various settings are included in the [RACP's Physicians and paediatricians: essential to multidisciplinary care](#).⁹

⁵ Consultmed. Queensland eConsultant Service. Consultmed. 2025. [Queensland eConsultant Service | Consultmed](#)

⁶ Christley, Jeremy, et al. "Evaluation of the geriatrician in the practice model of care for dementia assessment and management in rural Australia." *Australian Journal of Rural Health* 30.1 (2022): 55-64.

⁷ Hiscock H, O Loughlin R, Pelly R, et al. Strengthening care for children: pilot of an integrated general practitioner-paediatrician model of primary care in Victoria, Australia. 2020. *Aust Health Rev*. 44(4):569-575. doi:10.1071/AH19177. [Strengthening care for children: pilot of an integrated general practitioner-paediatrician model of primary care in Victoria, Australia - PubMed](#)

⁸ Royal Australasian College of Physicians, Complex care, consultant physicians and better patient outcomes (2019) - <https://www.racp.edu.au/docs/default-source/advocacy-library/c-final-mccm-document.pdf>

⁹ Royal Australasian College of Physicians. Physicians and paediatricians: essential to multidisciplinary care. RACP. 2024. [racp-brief-to-inform-the-unleashing-the-potential-of-our-workforce-scope-of-practice-review---overview-of-the-role-of-physicians-and-paediatricians-in-the-australian-government-s-primary-care-reform.pdf](#)

The RACP and its members would welcome the opportunity to work with the Department on how Medicare can support evolving, innovative and fit for purpose collaborative care models, particularly how the MBS system can appropriately support them. Unfortunately, the current MBS items are generally not fit for purpose to support these items, particularly those involving direct physician to GP advice.

Recommendations to enhance digital modernisation and interoperability

Recommendation 7: Implement the Strengthening Medicare recommendation to “modernise My Health Record to significantly increase the health information available to individuals and their health care professionals”:

- Fund incentives and software interoperability platforms for physicians consistent with funded supports for General Practice, to enable and prepare for ‘sharing by default’ requirements.
- Fund enabling digital enhancements for interoperability between My Health Record and other different digital health systems in private and public healthcare settings.
- Continue work towards improving usefulness of clinical information in My Health Record to ongoing patient care, particularly access by physicians to critical information from other health professionals
- Streamlining My Health Record uploading processes to reduce administrative burdens.

Recommendation 8: Fund the development and expansion of new collaborative models of care to reduce unnecessary formal referral episodes and support efficient GP-to-non-GP-specialist collaboration, with MBS item changes to support these models.

Next steps

Modernising referral pathways is a necessary step in aligning Australia's health system with the realities of contemporary clinical practice – particularly the growing burden of chronic and complex disease requiring long term, coordinated, multidisciplinary specialist care.

The RACP's overarching position is that referral arrangements should

- **support collaborative and team-based models of care**
- **reduce unnecessary administrative burdens**
- **align with value-based care principles, and**
- **ensure that patients with complex needs are not disadvantaged by outdated administrative requirements.**

The RACP would welcome the opportunity to engage further with the Department on the implementation of these reforms and is available to provide additional information or expert input as required.

For further queries or information, please contact Christian White, Policy and Advocacy Officer, via policy@racp.edu.au.