

Submission by the Australian Nursing and Midwifery Federation

Australian Government Department of Health, Disability, and Ageing - Modernising Referral Pathways

13 March 2026



**Australian
Nursing &
Midwifery
Federation**

Annie Butler
Federal Secretary

Catelyn Richards
Federal Assistant Secretary

Australian Nursing and Midwifery Federation
Level 1, 365 Queen Street, Melbourne VIC 3000
E: anmffederal@anmf.org.au
W: www.anmf.org.au



Key Points

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country. The ANMF welcomes the opportunity to provide feedback on the Department of Health, Disability, and Ageing's consultation paper on modernising referral pathways.

1) Referral validity periods are not fit for purpose

- a) Reform should ensure that consumers are well informed and at the centre of their own care and that the referral system supports the best consumer outcomes and experiences and minimises financial and practical burden on consumers first and foremost.
- b) Current referral validity periods of 12-month (GP to specialist) and 3-month (specialist to specialist) create unnecessary barriers for consumers.
- c) The ANMF recommends indefinite referral validity for chronic disease management supported by clear communication pathways between clinicians. This would reduce unnecessary GP appointments, reduce costs, ease administrative load on clinicians, and would help to ensure referrals don't expire while patients are stuck on long waitlists.

2) Nursing and midwifery should be central to referral reform

- a) Current MBS rules significantly restrict nurse practitioners (NPs) and endorsed midwives from making direct referrals despite being clinically qualified. The ANMF recommends:
 - i) Expanded referral authority for NPs and midwives.
 - ii) Funding and policy settings that allow them to practice to full scope.
 - iii) Greater use of nurse- and midwife-led care coordination models.

3) Digital referral system - opportunities and barriers

- a) Potential benefits include streamlined access, fewer lost referrals, better information flow.
- b) Risks and barriers include poor interoperability between clinical software systems; added administrative burden if poorly designed; change fatigue in already stretched workforces, and data privacy and cybersecurity concerns.

4) Improving consumer understanding and transparency

- a) The ANMF supports:



- i) Consumers always receiving a copy of their referral.
- ii) Clear information in plain language with consideration of culturally and linguistically diverse consumers.
- iii) Links to cost information and out-of-pocket estimates.
- iv) Funded initiatives to improve consumer health literacy especially for vulnerable groups.
- v) A standardised national referral template and digital patient summaries.

5) Billing rules are confusing and create errors

- a) Definitions of “initial” vs “subsequent” specialist attendances are opaque and frequently cause incorrect billing and confusion for consumers and clinicians.
- b) The ANMF recommends shifting from time-based rules (e.g., the 9-month rule) to a condition-based framework (i.e. for specified long term chronic conditions).

6) Support for second opinions

- a) Allowing second opinions under the same referral would reduce cost and improve consumer choice and control but must be paired with mandatory communication back to the original referrer to maintain coordinated care.

7) Additional system-level recommendations

- a) Invest in multidisciplinary primary care teams to reduce unnecessary referrals.
- b) Scale up nurse-led triage, navigation, and chronic disease management roles.
- c) Strengthen midwifery continuity-of-care models and referral autonomy.
- d) Ensure digital reforms support and not replace nursing and midwifery models of care.



Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.
2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.
3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.
4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.
5. The ANMF welcomes the opportunity to provide feedback on the Department of Health, Disability, and Ageing's consultation paper on modernising referral pathways. In our submission, the ANMF contends that broadly, the current referral pathway and attendant Medicate referral arrangements are not suitable for the needs of consumers or practical in terms of the effective operation of today's health care system. With the implementation of new reforms, Australia's referral pathways could be reconfigured to ensure person-centered care is at the forefront of a new fit for purpose healthcare system.
6. The current framework governing referral validity in Australia is often more reflective of legacy administrative systems than contemporary clinical realities. Our submission argues that the evolution toward person-centred care requires a fundamental shift in how we manage the access specialist services and ensuring full use and support for the nursing and midwifery workforces in this sector. By prioritising the consumer's clinical needs and preferences over largely subjective time-



based limits, particularly for those managing chronic or long-term conditions, we can remove systemic bottlenecks that currently penalise the most vulnerable and those in the community with least access and ability to afford healthcare. Extending referral validity indefinitely for chronic care is not just a logistical adjustment, it is an equity-focused reform designed to protect continuity of care and ensure that clinicians spend their time delivering outcomes rather than navigating paperwork.



Consultation Questions

Q1. The current referral process makes it easy for patients to access specialist care.

- 1 - Strongly disagree
- 2 - Somewhat disagree**
- 3 - Neither agree nor disagree
- 4 - Somewhat agree
- 5 - Strongly agree
- N/A - Not applicable

Q2. Common referral validity periods (12 months for GP referrals, 3 months for specialist-to-specialist referrals) meet health needs.

- 1 - Strongly disagree**
- 2 - Somewhat disagree
- 3 - Neither agree nor disagree
- 4 - Somewhat agree
- 5 - Strongly agree
- N/A - Not applicable

Q3. Longer or indefinite referral validity periods would improve patient experience and reduce unnecessary costs.

- 1 - Strongly disagree
- 2 - Somewhat disagree
- 3 - Neither agree nor disagree
- 4 - Somewhat agree
- 5 - Strongly agree**
- N/A - Not applicable

Q4. Patients should always receive a copy of their referral.

- 1 - Strongly disagree
- 2 - Somewhat disagree
- 3 - Neither agree nor disagree
- 4 - Somewhat agree



5 - Strongly agree

N/A - Not applicable

Q5. Including cost information and links to Medical Costs Finder on referrals would help patients make more informed financial decisions.

1 - Strongly disagree

2 - Somewhat disagree

3 - Neither agree nor disagree

4 - Somewhat agree

5 - Strongly agree

N/A - Not applicable

Q6. Patients should be able to switch specialists under the same referral without needing a new referral.

1 - Strongly disagree

2 - Somewhat disagree

3 - Neither agree nor disagree

4 - Somewhat agree

5 - Strongly agree

N/A - Not applicable

Q7. The treating non-GP specialist should be required to inform the referring doctor of a patient's treatment progress throughout the duration of the referral.

1 - Strongly disagree

2 - Somewhat disagree

3 - Neither agree nor disagree

4 - Somewhat agree

5 - Strongly agree

N/A - Not applicable



Q9. For GP to non-GP specialist referrals, which validity period do you think would be most appropriate?

1 - 12 months

2 - 24 months

3 - Indefinite

- Other (Please specify below)

7. The current administrative framework governing specialist referrals often functions as a barrier rather than a facilitator of high-quality care. Historically, fixed-term referral validity periods were designed largely as a fiscal and administrative control, however, in the context of contemporary Australian healthcare, these limits frequently conflict with the principles of person-centred care. By removing the requirement for unnecessary appointments, reforms can alleviate the financial and logistical strain on consumers while simultaneously reclaiming the time of busy healthcare professionals.
8. Decisions regarding establishing appropriate validity periods for referrals should be guided by considerations that embed person-centredness in care coordination and delivery and the prioritisation of the consumer's clinical needs and preferences over subjective administrative limits. For consumers living with chronic or long-term conditions requiring ongoing care, an indefinite referral validity is clinically appropriate. For these referrals, there must be a clear communication pathway between the treating clinicians to ensure that safety nets are in place to support the consumer to receive appropriate and timely care. Systemic inefficiencies in the current referral process including unnecessarily short referral validity periods disproportionately affect consumers already navigating long waitlists, the availability and accessibility of specialists, and increasing financial pressures. With careful implementation and appropriate consumer health information and support, extending referral validity periods indefinitely is a practical, equity-focused reform that would protect continuity of care and ensure consumers are not penalised for delays beyond their control.
9. Indefinite validity periods for referrals would also lessen financial and logistical strain on consumers, who would otherwise be required to schedule additional appointments solely to renew referrals. Beyond ensuring more effective and appropriate care for consumers, extending referral validity



periods indefinitely also reduces unnecessary administrative burden on health care professionals, enabling them to focus on delivering care rather than repeatedly processing paperwork.

Q10. For non-GP specialist to non-GP specialist referrals, which validity period do you think would be most appropriate?

1 - 3 months

2 - 12 months

3 – 24 months

4 - Indefinite

5 - Other (Please specify below)

- ¹⁰. Extending the validity of referrals from non-GP specialists to non-GP specialists is critical for supporting consumers to receive the care they need when they need it. Currently, as the consultation paper recognizes, the short validity period of three months for these referrals is not focused on the best interests of the consumer and causes increased financial and administrative burden on consumers and clinicians alike.⁽⁴⁾

Q7. What risks or challenges do you foresee with making referrals longer or indefinite by default

11. As outlined by the consultation paper, the current validity periods for referrals are not well aligned with the contemporary healthcare landscape in Australia. Current extended waiting times for surgical intervention following initial consultation mean that referrals frequently expire before a consumer can access their scheduled procedure⁽¹⁾. This can create an unnecessary and avoidable barrier to accessing timely care. Increasing the validity period of referrals would enable improved consumer access to specialist care and greater continuity of care. The implementation of reforms to extend referral validity periods will ensure more streamlined access to care and decrease the financial burden for consumers.

¹ Prime S, Gardiner C, Haddock R. Optimising health care through specialist referral reforms. Deeble Institute for Health Policy Research Issues Brief No: 38. Canberra: Australian Healthcare and Hospitals Association; 2020. Available from: https://ahha.asn.au/wp-content/uploads/2023/11/deeble_brief_no_38_optimising_healthcare_through_specialist_referral_reforms_0.pdf



12. While extending referral validity periods would be a welcome reform that would strengthen continuity of care in primary healthcare when embedded within structured governance arrangements, careful consideration is required to ensure that potential risks are mitigated. Ensuring that consumers' care is well coordinated will be vital to prevent potential duplication of services, ineffective interfaces and information sharing between different health professionals, extended waiting times, and increased costs for consumers. Nurses working in primary healthcare including nurse practitioners (NPs) are well-placed to provide care coordination in many contexts.⁽²⁾ While indefinite referrals are currently available in limited circumstances, broader implementation must be supported by clear, accountable frameworks that maintain active involvement of GPs, nurse practitioners (NPs), and midwives in care coordination and clinical oversight. The *Unleashing the Potential of Our Health Workforce – Scope of Practice Report* recommends the prioritised implementation of certain direct referral pathways including referrals by midwives and NPs to certain non-GP specialists.⁽³⁾

13. With careful planning and implementation, potential risks that could arise from extending the validity period would be avoided, including the potential that consumers might utilise expensive specialist-led care rather than continuing to access holistic, centrally coordinated care provided by their primary health practitioner such as their GP, nurse practitioner (NP), or midwife. With ongoing engagement with and coordination of care from primary care providers, consumer needs can be regularly reviewed to ensure that care remains clinically appropriate and well-coordinated across primary healthcare and specialists.

14. Together with careful implementation of extended referral validity periods, investment in health education for consumers is critical. Consumers must be supported to be active partners in their healthcare and to understand the referral options available to them within an increasingly complex

² Karam M, Chouinard MC, Poitras ME, Couturier Y, Vedel I, Grgurevic N, et al. Nursing care coordination for patients with complex needs in primary healthcare: a scoping review. *Int J Integr Care*. 2021;21(1):16. Available from: <https://pmc.ncbi.nlm.nih.gov/articles/PMC7977020/>

³ Australian Government Department of Health and Aged Care. *Unleashing the potential of our health workforce: scope of practice review – final report*. Canberra: Commonwealth of Australia; 2024. Available from: <https://www.health.gov.au/resources/publications/unleashing-the-potential-of-our-health-workforce-scope-of-practice-review-final-report>



health system. Empowering consumers with accessible, evidence-based information and resources will promote enhanced health outcomes and a cost-efficient health system.⁽⁴⁾

Q11. What do you foresee slowing or stopping the take up of a future Australia wide digital referral process?

15. A national digital referral process has strong potential to improve coordination and access to care, but several structural and systemic factors could slow or even halt its uptake. Geographic inequity presents a significant challenge and must be addressed to ensure a where a person lives or works does not detrimentally impact their ability to access or refer a patient to equitable care. Rural and remote practices may have less reliable connectivity to the national broadband network or poor access, with fewer IT support resources, and smaller administrative support teams.⁽⁵⁾ Where the system depends heavily on real-time connectivity or requires ongoing technical troubleshooting, uptake may lag outside of metropolitan areas, creating a two-tier system and weakening the case for a truly national model.
16. Another significant barrier is the varying capability of clinical software systems that are used by services to access Medicare. Both general practices and specialist doctor's rooms use a range of different systems, and interoperability between them is inconsistent. Our members employed in primary health care and general practice tell us that where the national referral process does not integrate seamlessly into existing GP and specialist workflows, clinicians face duplication of work, formatting issues, and unreliable information transmission. While digital referrals are broadly welcomed, when errors do occur such as when a referral is rejected, long waiting times can result which impact upon practice nurses' workloads as they seek to rectify the problems over the phone. Other workflow disruptions can also be a risk. Where a digital referral system requires additional structured data fields, multiple authentication steps, or time-consuming navigation, further administrative burden is added for clinicians. In sites or regions facing workforce shortages and long

⁴ Hickmann E, Richter P, Schlieter H. All together now – patient engagement, patient empowerment, and associated terms in personal healthcare. BMC Health Serv Res. 2022;22(1):1116. doi: 10.1186/s12913-022-08501-5. Available from: <https://link.springer.com/article/10.1186/s12913-022-08501-5>

⁵ Parke E. Digital divide report shows thousands of Australians in remote communities still don't have internet access. ABC News. 2024 Dec 10. Available from: <https://www.abc.net.au/news/2024-12-10/digital-divide-report-remote-communities-internet-access/104694460>



waitlists, even a well-streamlined referral process implemented poorly and without the surrounding infrastructure and workforce has the potential to increase referral volume and workloads without addressing underlying limitations. Here, referrers and specialists may resist systems that increase administrative load or introduce rigid requirements without real world efficiency gains. This highlights that without clear and immediate efficiency gains in terms of workflow efficiency at the point of care, clinicians are unlikely to embrace changes readily.

17. Change fatigue is another factor that should not be underestimated, particularly where staff are not well supported to implement new technologies and ways of working or where an insufficient number of staff are already working under excessive pressure with limited resources. Introducing another system, particularly if its value is not clearly articulated and immediately experienced, may lead to challenges with implementation and uptake.⁶ These cumulatively impactful inefficiencies and hurdles can discourage or halt new technology adoption by busy staff in time-pressured primary care settings, but with careful planning, co-design with clinicians, experts, and consumers, preparation, implementation, and support they can be resolved or mitigated.⁷
18. Another factor that could impede implementation and uptake is concern around data privacy and cybersecurity. Recently, there have been many publicised incidents where widely trusted data systems have suffered security and data breaches (e.g., Medibank and Optus).⁸ These breaches are legitimate concerns for both clinicians and consumers and erode trust and uptake of new information technologies. A new digital referral platform that stores and transmits sensitive and identifiable clinical information must be secure, trustworthy, and maintained with robust and transparent governance. Even a single significant breach during early implementation could seriously undermine trust and derail national rollout. This raises the importance of ensuring that systems are supported with sufficient investment to underpin the necessary ongoing maintenance and updates necessary to ensure continued safety and performance.

⁶ Beaulieu L, Seneviratne C, Nowell L. Change fatigue in nursing: An integrative review. *J Adv Nurs*. 2023;79(2):454-470. doi: 10.1111/jan.15546.

⁷ Härkönen H, Lakoma S, Verho A, Torkki P, Leskelä RL, Pennanen P, et al. Impact of digital services on healthcare and social welfare: An umbrella review. *Int J Nurs Stud*. 2024;152:104692. doi: 10.1016/j.ijnurstu.2024.104692.

⁸ Australian Cyber Security Centre. Optus data breach. Canberra: Commonwealth of Australia; 2022 Sep 23.

Available from: <https://www.cyber.gov.au/about-us/alerts/optus-data-breach>



Q12. Are there any other issues related to referrals that have not been captured in this consultation paper?

19. By positioning nursing and midwifery at the centre of referral redesign, Australia could improve care access, affordability, and efficiency while strengthening the sustainability of the broader health system and mitigating demands on busy general practices. Beyond reforming Australia's referral system, greater and sustained investment in multidisciplinary primary care teams is critical. Many specialist referrals occur because existing primary care services lack the funding and workforce capacity for extended management of complex conditions. Expanding team-based funding that supports nurses in chronic disease clinics, mental health follow-up, preventive care, and post-discharge review could reduce avoidable referrals and decrease burden on already struggling hospital services and busy, hard to access specialists.
20. Enabling NPs to practice to the full extent of their education and training through implementing the recommendations of the national NP review, particularly in rural and remote communities, directly improves equity of access.⁽²⁾ In areas with limited GP supply, nurse-led primary care clinics with funded referral authority would also support timely access to specialist care without requiring patients to travel long distances simply to obtain a referral – often to a specialists with long waitlists that demand even more travel.
21. Modernising the Medicare referral pathway presents an opportunity to not only to digitise existing processes, but to rebalance models of care to better utilise the nursing and midwifery expertise that already exists within primary health care. Nursing and midwifery models of care emphasise person-centred, continuity-based care and are known to be safe and effective. Digital tools and interoperability standards remain valuable, but they should support, not replace, models of care led by nurses and midwives. Policy development must include and strengthen nurse- and midwife led models of care that improve access and affordability while maintaining quality and safety and ensuring that these models are suitably supported by Medicare.
22. For effective reform, NPs and endorsed midwives must have funding structures in place to initiate and manage referrals within their scope of practice. Nurse practitioners are already qualified to assess, diagnose and refer, yet Medicare settings and funding limitations can constrain their full contribution. This hampers their ability to provide timely, effective care and impacts their patients



access to that care. Addressing these issues with Medicare would allow consumers, especially in rural and underserved areas, to access specialist pathways particularly where access to GPs is challenging, as well as without unnecessary duplication of GP consultations. This would reduce bottlenecks by expediting safe and effective nurse-led care.

23. Another reform could be scale-up of embedded nurse-led triage and care navigation roles within primary care practices and Primary Health Networks. International evidence shows that nurse-led coordination improves continuity and reduces unnecessary specialist appointments.⁽⁹⁾ In Australia, formalising and funding these roles could improve referral quality and reduce rejected or incomplete referrals, thereby enhancing efficiency without relying solely on new digital infrastructure.
24. Midwifery continuity-of-care models provide another important pathway for consumers to access timely, high quality care. Strengthening referral autonomy and funding for endorsed midwives within collaborative arrangements will undoubtedly reduce fragmentation in maternity care and enhance access to care. Midwife-led primary maternity care, with clear and streamlined referral escalation pathways to obstetric services where clinically indicated has been shown to improve outcomes and client satisfaction while reducing the number of unnecessary interventions.⁽¹⁰⁾ This both saves costs and improves health outcomes and experiences.

Q13. Are there any alternative policy options that you would recommend that have not been discussed in this consultation paper?

25. There is a distinct lack of recognition of the need for improved referral pathways for nurses and midwives in the consultation paper. To ensure strengthened reforms are successful, the current state of the healthcare system must be considered. Modern health systems include advanced practice clinicians in nursing and midwifery who lead and coordinate care. That lack of inclusion

⁹ Randall S, Crawford T, Currie J, River J, Betihavas V. Impact of community based nurse led clinics on patient outcomes, patient satisfaction, patient access and cost effectiveness: A systematic review. *Int J Nurs Stud.* 2017;73:24–33. doi: 10.1016/j.ijnurstu.2017.05.008.

¹⁰ Fikre R, Gubbels J, Teklesilasie W, Gerards S. Effectiveness of midwifery-led care on pregnancy outcomes in low- and middle-income countries: a systematic review and meta-analysis. *BMC Pregnancy Childbirth.* 2023;23(1):386. doi: 10.1186/s12884-023-05664-9.



creates higher burdens on consumers, GPs, and creates barriers for nurses and midwives to provide care to the full extent of their scope.

26. Referrals made by nurses and midwives to non-GP specialists are highly restricted. The *Unleashing the Potential of Our Health Workforce – Scope of Practice Review Report* ⁽²⁾ outlines that such restrictions are more through application of MBS rules rather than by limitations on scope of practice of the referring health professional. The report highlights the fundamental issues for nurses and midwives such as constraints on professional judgement and scope of practice, and barriers for consumers such as reduced affordability and delayed access to care. It recommends the implementation of direct referral pathways supported by technology that enables health professionals to make referrals within their scope of practice to access care for consumers.
27. In addition to these specific referral pathways, the ANMF further advocates for NPs to have access to the same referral pathways as medical officers to improve access to quality healthcare, particularly for consumers in rural and remote areas where consistent GP access may be limited. The implementation of this recommendation would strengthen the intended objectives of this consultation and provide more cost-efficient mechanisms to support reducing the economic burden of healthcare delivery.

Q14. Which of the following descriptions best suits you?

- 1 - I am a healthcare consumer
- 2 - I am a referring practitioner.
- 3 - I am a practitioner referrals are made out to.
- 4 - I am a practitioner who both refers patients and receives patient referrals.
- 5 - I am a representative of a peak body or research institute.**



Consultation Questions for Representatives of Peak Bodies and Research Institutes:

On a scale of 1-5, where 1 means you disagree completely and 5 means you strongly agree, how much do you agree with the below statements?

Q1. Consumers understand current referral arrangements, including who can issue them, how they can be used, and what their rights as patients are.

- 1 - Strongly disagree
- 2 - Somewhat disagree**
- 3 - Neither agree nor disagree
- 4 - Somewhat agree
- 5 - Strongly agree
- N/A - Not applicable

28. While most consumers are likely to be generally familiar with the concept of needing a referral to see a specialist for care, many consumers would be likely to have a detailed understanding of the logistics, validity, and specific rights associated with them. Most Australians are likely to view the GPs as the main "gatekeeper" for referrals to specialists, despite the growing number of NPs. While awareness is growing and consumers are becoming more active in their care, significant gaps can remain in terms of consumer awareness regarding other referrers and the logistics and policies that surround these, as well as their rights as patients.¹¹ Importantly, healthcare literacy and the ability to navigate often complex health information and systems varies between individuals and groups of people. People who are culturally and linguistically diverse or unfamiliar with Australia's healthcare system are likely to have a more limited understanding of referral arrangements, who can issue them, how they can be used, and what their patient rights are.

Q2. Referrals currently contain enough information for non-GP specialists to provide appropriate care.

- 1 - Strongly disagree**
- 2 - Somewhat disagree
- 3 - Neither agree nor disagree

¹¹ Malcolmson D. The patient's right to know. J Med Regul. 2015;101(3):32-36.



4 - Somewhat agree

5 - Strongly agree

N/A - Not applicable

29. A 2025 systematic review found that while referrals generally meet basic legal requirements, there is a significant information gap between what GPs provide and what non-GP specialists need to provide high-quality care.¹² Improving the rate and appropriateness of referrals for chronic conditions requires a multi-faceted approach rather than a single, isolated fix. Research indicates that while structured proformas and educational interventions are helpful, they are most effective when integrated into broader multi-component strategies that include system-wide changes like electronic health records and collaborative working models. In one included study, roughly 69% of GPs believed they include all relevant clinical information in their referral, this contrasted with only 35% of specialists reporting receiving the details they actually need.

30. The success of any referral intervention is heavily dependent on the specific clinical context, meaning there is no "one-size-fits-all" solution that works across every healthcare setting. Implementation is frequently hindered by the systemic barriers outlined above, including chronic time constraints, logistical complications, as well as existing perceptions held by both patients and medical staff regarding the necessity of a specialist consult. The review suggests that the most successful way to bridge the gap between primary and secondary care is to implement interventions that simultaneously address the unique barriers faced by both referrers and specialists.

Q3. The current referral default/maximum validity periods (12 months for GP referrals, 3 months for non-GP specialist-to-non-GP specialist referrals) reflect the clinical needs of patients.

1 - Strongly disagree

2 - Somewhat disagree

3 - Neither agree nor disagree

4 - Somewhat agree

¹² Bolton Saghdaoui L, Lampridou S, Tavares S, Lear R, Davies AH, Wells M, et al. Interventions to improve referrals from primary care to outpatient specialist services for chronic conditions: a systematic review and framework synthesis update. *Syst Rev.* 2025;14(1):103. doi: 10.1186/s13643-025-02741-2.



5 - Strongly agree

N/A - Not applicable

Q4. Extending referral validity periods would better support patients with chronic and complex conditions.

1 - Strongly disagree

2 - Somewhat disagree

3 - Neither agree nor disagree

4 - Somewhat agree

5 - Strongly agree

N/A - Not applicable

Q5. Rules around billing initial versus subsequent attendance items are clear.

1 - Strongly disagree

2 - Somewhat disagree

3 - Neither agree nor disagree

4 - Somewhat agree

5 - Strongly agree

N/A - Not applicable

31. The rules regarding "initial" versus "subsequent" attendance items can be profoundly unclear to both consumers and the nursing/medical workforce. While these terms sound straightforward, the Medicare Benefits Schedule (MBS) defines them through complex legal "notes" (such as Note AN.0.7) that frequently lead to billing errors and consumer frustration. As described under Note AN.0.7; the payment of benefit may be made for each of several attendances on a patient on the same day by the same medical practitioner, but only provided the subsequent attendances are not a continuation of the initial or earlier attendances. There must be a "reasonable lapse of time" between such attendances before they can be regarded as separate attendances. Likewise, a subsequent attendance on the same day can constitute a continuation of an earlier attendance. For example, an appointment for a prescription for a vaccine with subsequent attendance for the injection should be considered one attendance, and this might not be clear to billers or consumers.



Patients can also be surprised when a "subsequent" specialist visit is billed at an "initial" rate because their referral expired or a new, unrelated condition was discussed.

32. For NPs and practice nurses, there can also be challenges. For NPs, who are able to bill Medicare directly, the challenge is often rooted in the application of definitions around billing for initial and subsequent appointments. The Medicare Benefits Schedule (MBS) defines an initial attendance (such as Item 82200) very specifically. If an NP sees a patient for a new diagnosis, it's an initial visit. However, if the patient returns two weeks later for the same issue, it becomes a subsequent visit (Item 82205), which attracts a lower rebate. For nurses working in general practice, a different challenge can arise. Since they usually cannot bill their own attendance items, they must ensure the GP's billing aligns with the work the nurse actually did. If a nurse performs a "subsequent" check-up on a chronic disease plan but the GP accidentally bills it as an "initial" consultation, the nurse is often the one who has to catch the error, explain the mistake to a frustrated patient, and manually fix the digital record.

Q6. Removing or modifying the rule allowing the billing of initial attendance items when a patient hasn't seen their non-GP specialist for more than 9 months would improve billing compliance.

- 1 - Strongly disagree
- 2 - Somewhat disagree
- 3 - Neither agree nor disagree
- 4 - Somewhat agree**
- 5 - Strongly agree
- N/A - Not applicable

Q7. What measures do you think would improve patient understanding of referral arrangements?

33. Based on current reform initiatives like the National Health Reform Agreement and recommendations from the Consumers Health Forum, several measures are being explored that would improve patient understanding of referral arrangements. These should be rolled out in tandem with any planned reforms. A primary barrier to understanding referral arrangements is that patients often never see, or have limited understanding of, the content of their referrals. Ensuring all referrals and specialist letters are uploaded to a central hub by default would help allows



patients to review the "referral question" and validity dates at their own pace. This needs to be supported by digital "Consumer Summaries" or simplified, plain-language summaries of the referral that are accessible to consumers. This can occur within the My Health App and be provided in paper, explicitly stating the expiry date and the patient's right to choose a different provider. Standardising consumer-facing information and templates would also assist as referrers currently use varied templates that prioritise clinical shorthand. Proposed measures include plain English proformas with guides for non-English speakers, and redesigned referral templates to include a mandatory "patient information" section that explains, in non-medical terms, why the referral is being made and what the expected next steps are. Integrating informed financial consent into the referral process, requiring the system to provide patients with an estimate of potential out-of-pocket costs for the specialty they are being referred to would also be ideal.

34. Community education and health literacy programs are also necessary. As the Consumers Health Forum has recommended, this could occur via a federally funded "Understanding Medicare" campaign. Further specific measures could include creating standardised infographics that show the "life of a referral" (e.g., from primary referring professional to specialist to allied health practitioner). Incorporating health literacy checks into health professional accreditation standards, where practitioners are encouraged to have the patient explain back their understanding of where they are going and why, might also be a promising reform that could help embed health literacy improvement into the way more health professionals deliver care in the first place and place consumers centrally to their care.

Q8. Is the rule allowing the billing of initial attendance items when a patient hasn't seen their non-GP specialist for more than 9 months (and the referring GP considers a review is required) clinically necessary?

35. While intended to ensure clinical safety and GP engagement and coordination, this rule has increasingly become an administrative hurdle for patients with stable, lifelong conditions whose treatment changes little over time. It is recommended that the Australian Government decouple the initial attendance billing trigger from a rigid chronological timeframe (nine months) for a specified list of verified chronic and permanent conditions. Likewise, ensuring that the system incorporates referrals and clinical management by health professionals other than GPs is necessary. In its place,



the Department should implement a condition-based referral framework. For patients with listed lifelong conditions (e.g., Type 1 Diabetes, Multiple Sclerosis, Congenital Heart Disease), referrals should remain valid (e.g., for a period of up to three years). During this period, all specialist visits should be billed as subsequent attendances, unless a new, unrelated clinical issue arises. This coupled with automated referral validity tracking via My Health Record would provide real-time alerts to both patients and practices when a referral is nearing its expiration. Further, shifting the definition of an "initial attendance" from "time elapsed" to "clinical change" would ensure that a higher-rebate initial assessment would only be billable if the primary health professional's referral explicitly requests a comprehensive management overhaul or if the specialist identifies a significant change in the patient's disease progression.

Q9. What risks and/or benefits do you anticipate if rules change to allow patients to seek a second opinion from a new specialist under the same referral?

36. Under current rules, while a referral technically applies to a specialty (not just a named individual practitioner), billing for a second opinion is often blocked unless a new referral is issued, as the first specialist exhausts the initial attendance item for billing purposes. Risks if improperly managed include potential fragmentation of care, siloing of data, and additional administrative complexity while benefits include reduced financial barriers to care for consumers and better consumer choice, potentially quicker diagnostics, and greater fairness for specialists by accounting for the workload involved in undertaking a full assessment of a consumer's presenting condition.
37. The consultation paper's suggestion that any specialist providing a second opinion under an existing referral should be required to send a clinical report back to the original referring health professional is sound. This ensures that even if the patient bypasses the original referring health professional, they remain informed and able to help coordinate the consumer's journey if necessary.