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Optimising health care through specialist referral reforms

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Key messages

- The specialist referral system is a key operational component of the Australian health system. It is designed to manage access to subsidised specialist services and remunerate MBS Providers at referred service rates. It is also designed to affirm the central role of primary healthcare services. The regulatory requirement for patients to obtain repeat referrals when already under the care of a specialist has received limited scrutiny since the 1970s.
- Using referral expiration as a means of triggering GP involvement fails to optimise the skills of the health workforce and burdens patients and the health system with regulatory-led GP engagement that offers limited clinical benefit to patients.
- Moving towards a health service model that places a greater emphasis on the appropriateness of the referral above the profession of the referrer is necessary to bring the referral rules in line with contemporary health needs and service structures.
- To achieve this will require a well-co-ordinated, effective and efficient referral system that facilitates the evidence-based and linear transfer of care from one clinician to another within a highly interoperable and collaborative healthcare system.
- The following recommendations are made to support improvements in the Australian referral framework:
    - Implement a national strategy for capturing and reporting standardised referral-related metrics.
    - Conduct an independent, evidence-based review of the referral system.
    - Decouple specialist billing from referral status and introduce protections against increased costs for patients under long-term specialist care.
    - Optimise the health workforce by expanding referral rights and adopting a linear evidence-based model of patient transfer through the health system.
    - Establish a dedicated principle and rules function within the Department of Health to support the interpretation, implementation and routine revision of referral rules.
    - Invest in health system interoperability and mandate real-time health information exchange between multidisciplinary care teams to facilitate high quality, coordinated and continuous care.

Executive summary

A medical referral is an integral part of a patient's journey through the health system, facilitating their transition between service providers. However, the rules governing referral practices can limit how efficiently this can be achieved and may not support high-value patient-centred care. The referral system was formalised in 1970 based on existing practices between general practitioners and specialists and has received limited independent and evidenced-based review since then.

The rise of chronic illnesses and multimorbidity highlights fundamental inefficiencies in the referral system, as more patients require long-term specialist care beyond standard 3-and-12-month periods of referral validity. The expiration of a referral while a patient is receiving ongoing specialist care has created a rigid structure of patient health-service transition that is increasingly contrary to evidence-based health care.

Referral expiration means patients must obtain a repeat referral in order to maintain access to their MBS subsidised specialist care, which is most commonly from a GP (General Practitioner). This exposes patients to increased out-of-pocket costs and risks delayed or discontinued medical treatment. As referrals are inherently related to MBS billing practices, excessive health service utilisation under the referral system negatively impacts the ability to offer equitable and durable health services within the wider health system.

The 'gatekeeper' role of GPs in patient care is reinforced by legislation framing the referral system. However, GP engagement through referral expiration is a model that is based on opportunistic rather than purposeful clinical engagement.

Improving information sharing among service providers through real-time health information exchange would avoid the need for low-value administratively driven GP consultations and address any ongoing concerns by GPs regarding the impact of expanded referral pathways and periods of referral validity on continuity and coordination of care.

1 Australia's specialist referral system

On 1 November 1970, the Commonwealth Government enacted legislation formalising referral practices between medical professionals (Commonwealth of Australia, Parliamentary Debates, 1977; Commonwealth Department of Health, 1970). These have since been described as the 'key operational component of Australia's healthcare system' (Principles and Rules Committee, 2016). Referrals are written requests from one practitioner to another to investigate and provide an opinion on a patient's condition or problem, to offer treatment or management, or to undertake specific examinations or tests (Department of Health, n.d.).

As stated by former Minister for Health, Ralph Hunt, 'the referral requirements relate solely to the payment of medical benefits' (Commonwealth of Australia, Parliamentary Debates, 1977, p295). A written referral provides formal evidence that a referral has taken place and is a requirement of Medicare Benefits Schedule (MBS) billing. In theory, referrals are not needed to see a specialist in Australia, but they are necessary if patients wish to access subsidised specialist and consultant physician services[1] under the MBS in order to reduce their out of pocket costs.

Given the high and unregulated costs of private specialist fees in Australia, patients are heavily incentivised to obtain and maintain a valid referral to access more affordable specialist care (Johar, et al., 2016).

The manner of referrals, including who may legally issue and receive a referral, the kind of clinical information that must be included in the referral letter, and the period of a referral's validity are now principally governed by the Health Insurance Act 1973 (Cth) (the 'Act') and the Health Insurance Regulations (Cth), 2018 (the 'Regulations'). The Health Insurance (General Medical Services Table) Regulations (No. 2) (Cth), 2020, ('MBS Regulations') are also central to the operation of the referral system and outlines the rules of MBS billing.

For an MBS subsidy to be payable, a referral must have been validly issued and received prior to the specialist rendering the service (Regulations, r 101(1)). Certain exemption rules apply for lost, stolen, or destroyed referrals, or in cases of emergency (Regulations, r 101(2)-(3)).

1.1 *MBS subsidised referral pathways and periods of referral validity*

A limited range of health care professionals are eligible to issue specialist referrals for MBS subsidised services under the Regulations, and this list has only been partially expanded beyond general practitioners (GPs) since 1970 (see Table 1).

Unless issued by a specialist, the default referral validity period is 12 months from the date a service is first rendered by the specialist under the referral (Department of Health, n.d). Once a referral expires, the patient is responsible for obtaining a repeat referral to maintain subsidised access to their specialist.

[1] The term specialist is used throughout this Issues Brief to denote both specialists and consultant physicians.

General practitioners, optometrists, and dental practitioners may issue referrals for a shorter or longer fixed timeframe, or indefinitely (Regulations, rr 96 and 102). MBS Online advises that 'referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management' (Department of Health, n.d.). However, this statement is not binding. The legally binding Regulations only require practitioners to consider the general 'need' for the referral (r 97). The Regulations do not list any factors that should be considered when determining the appropriate referral period.

Table 1. MBS Provider referral pathways and validity periods.

Referrer	Referee	Referral validity period
Medical practitioner	Specialist or consultant physician	Fixed period or Indefinitely or If no period is specified, 12 months after the first service is rendered
Optometrist	Ophthalmologist	
Approved dental practitioner	Specialist or consultant physician	
Non-approved dental practitioner	Specialist only	
Specialist or consultant physician	Specialist or consultant physician	3 months or If the referred patient is in hospital at the time of referral and continues to be so for more than 3 months – until the person ceases to be a patient in a hospital
Participating midwife	Obstetrician or paediatrician	12 months and one pregnancy
Participating nurse practitioner	Specialist or consultant physician	12 months

1.2 *Specialist to specialist referrals*

On 1 November 1996, a referral validity period of 3-months for specialist to specialist issued referrals was introduced into the Regulations. Although the Regulations do not expressly create a specialist to specialist referral pathway, they provide authority for specialists to issue referrals by stipulating their validity period and the information which must be included in the referral (Regulations, rr 96, 99 and 102).

The reason for the 3-month time frame is unclear. When the requirement was introduced, policy priorities were being driven by the Liberal and National Parties as part of a suite of proposed election reforms aimed at strengthening a primary care-led health system (see for example, Liberal and National Parties, 1996).

The increasing number of specialist-issued referrals each year is an emerging yet largely unquantified trend (Specialist and Consultant Physician Consultantion Clinical Committee, 2018). A non-exhaustive review of the literature reveals that specialist to specialist issued referrals have, in certain settings, accounted for between 14%-49% of referrals made to out-patient services (Ross et al., 2018; General Practice Australia, 2010; Kunin et al., 2018; Hiscock et al., 2011). For patients referred by a specialist, the 3-month period of referral validity means that referrals are highly likely to expire whilst specialist care is ongoing, requiring a repeat referral be sought.

The limited data available on how patients transition through the health system undermines effective service design and the prevalence of specialist-issued referrals should be evaluated in order to adequately assess referral trends beyond primary care. Data obtained through the MBS and referral management software could be used to evaluate these referral behaviours and assess the appropriateness of governing regulations to support the efficient transition of patients through the health system.

1.3 *The need for reform*

1.3.1 The MBS Review Taskforce

The MBS Review Taskforce was established by the Government in 2015 as a clinician-led review of the clinical suitability of more than 5,700 MBS items, and the broader legislative framework and financing structures associated with their use (Principles and Rules Committee, 2016). The vision of the MBS Review Taskforce was 'to ensure that the [MBS] provides affordable universal access to best practice health services that represent value for both the individual patient and the health system' (Principles and Rules Committee, 2016). Reviews were undertaken by clinical committees and groups who provided recommendations to the MBS Review Taskforce to consider before any endorsed but non-binding recommendations were then presented to Government.

When providing input to guide the MBS Review Taskforce process, the Consumer Health Forum of Australia (CHF) (2015) identified a number of key issues arising from the burden of referral validity periods, including out of pocket costs, the inconvenience and time taken to obtain a referral, and issues of choice around specialist referrals.

Despite these concerns, only the 3-month validity period for specialist-issued referrals was reviewed by the Principles and Rules Committee (2016) and the Specialist and Consultant Physician Consultation Clinical Committee (2018). The burden that short expiration referrals placed on health patients was noted by both Committees in addition to the Australian Medical Association (AMA) who suggested that:

"an option should be made available for the validity period to be extended beyond 3 months where the patient's clinical condition requires continuing care and management of a specialist or a consultant physician for a specific condition or specific conditions" (AMA, 2019, pg15).

However, both Committees expressed that the patient burden associated with specialist-issued referral validity periods was secondary to the interests of preserving the central role of the GP in patient care. Despite numerous stakeholder objections (for examples, see Appendix 1), the final reports of both Committees recommended the retention of the 3-month validity period for specialist-issued referrals without significant explanation or exploration of the complex issues surrounding the topic.

In relation to referral validity periods,

The Principles and Rules Committee noted:

"…numerous complaints from [patients] and providers. Examples include cancer patients who are receiving multi-modality treatment where the radiation oncology treatment lasts longer than 3 months." […]

"Notwithstanding concerns from [patients] and providers, the Committee agreed to maintain the 3-month limit on specialist-to-specialist referrals. The Committee noted the key role of the general practitioner as 'gatekeeper' to the broader health system and primary point of patient contact, and that the 3-month limit facilitated regular ongoing contact between patient and GP. This was seen to be especially important when the patient's condition changes or they develop new conditions, and these can be better and more efficiently managed by the GP."

(Principles and Rules Committee, 2016, pg29-30)

Specialist and Consultant Physician Consultation Clinical Committee noted:

"…that specialist-to-specialist referrals are increasingly common in modern clinical practice and considered recommending increasing their validity from 3 months to 6 months and mandating a copy of the referral be sent to the patient's GP aiming to increase patient convenience and reduce the incidence of expired referrals...[h]owever, the Committee noted that this topic was also considered by the Principles and Rules Committee, who recommended keeping referral validity to 3 months. Enabling GP oversight of patient care provided by consultant specialists was cited as the reason for keeping the validity at 3 months."

"The Committee noted that, while it may be less convenient for patients to return to their GP, evidence put forward by the [General Practice and Primary Care Clinical Committee] demonstrates that health outcomes are better when GPs are informed."

(Specialist and Consultant Physician Consultation Clinical Committee, 2018, pg73-74)

1.4 *Revision of the Health Insurance Regulations*

In 2018, following legislative sunsetting, the Health Insurance Regulations 1975 were remade. The sunsetting process provides an opportunity for parliamentary scrutiny and is designed to facilitate periodic legislative review to ensure instruments remain fit-for-purpose. In relation to remaking the Regulations, the Minister for Health, Greg Hunt, stated:

> '[a]s the Principal Regulations maintain the overarching policy framework, no formal consultation was undertaken on this regulation. The MBS Review Taskforce has reviewed and reinforced many of the principles that underpin Medicare which are contained within the Principal Regulations' (Hunt, 2018).

At this stage, the Principles and Rules Committee (2016) was the only committee to have made recommendations on referral validity periods as part of the MBS Review Taskforce prior to legislative sunsetting. In defaulting to the findings of this committee alone, the Government has endorsed the recommendations of a review process that was limited in scope and stakeholder engagement and not sufficient to address the many issues within the current referral framework that will continue to impact patients and the health system.

The Regulations are scheduled to be remade again on 1 October 2028, though under the powers of the Attorney-General, legislative review can occur at any time. With this in mind, an independent review of referral rules and practices should be established to guide more immediate reform of the regulations and ensure the rules that underpin referral practices within Australia are evidence-based, patient-centred and appropriate to support the changing health needs of the nation.

2 The changing health needs of the nation

2.1 *Chronic illnesses and long-term specialist care*

The number of patients with complex care needs in Australia is growing (Figure 1). In 2015, at least 50% of adults and 43% of children were living with a chronic disease (ABS, 2015; AIHW, 2020a); and more than 20% of Australians have two or more chronic illnesses (multimorbidity) (AIHW, 2016).

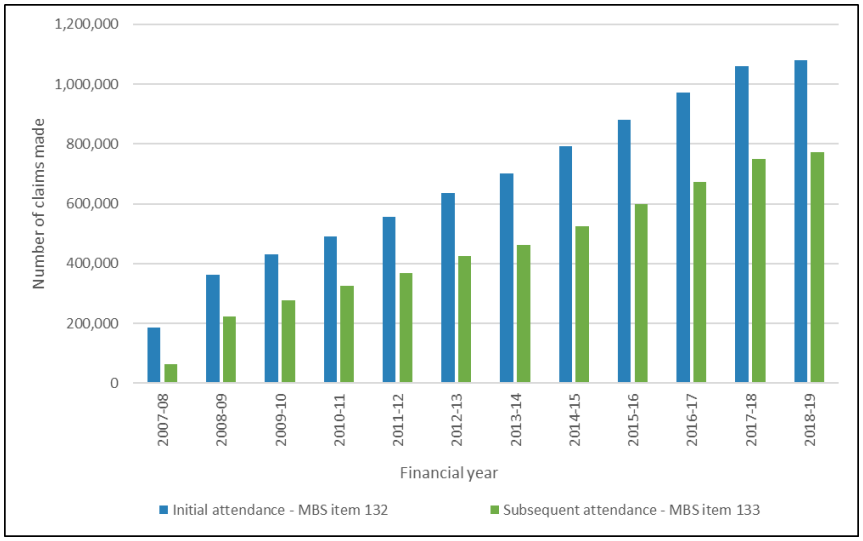


Figure 1: Claims by a patient with at least two morbidities (Services Australia, 2020).

The effective management of chronic disease and multimorbidity requires long-term multidisciplinary team-based care to support patients through their health journey (Harris, et al., 2013). However, Australia's referral system was developed in the 1970s when acute, not chronic, illnesses were more common and the need to be supported by numerous specialists over the long term was less likely (AIHW, 2016; Boxall and Gillespie, 2013; RACGP, 2019a). This change in health care requirements has placed pressure on the durability of the health system and will continue to do so if the referral system does not evolve in line with patient needs (Swerissen and Duckett, 2016).

Ageing and chronic disease

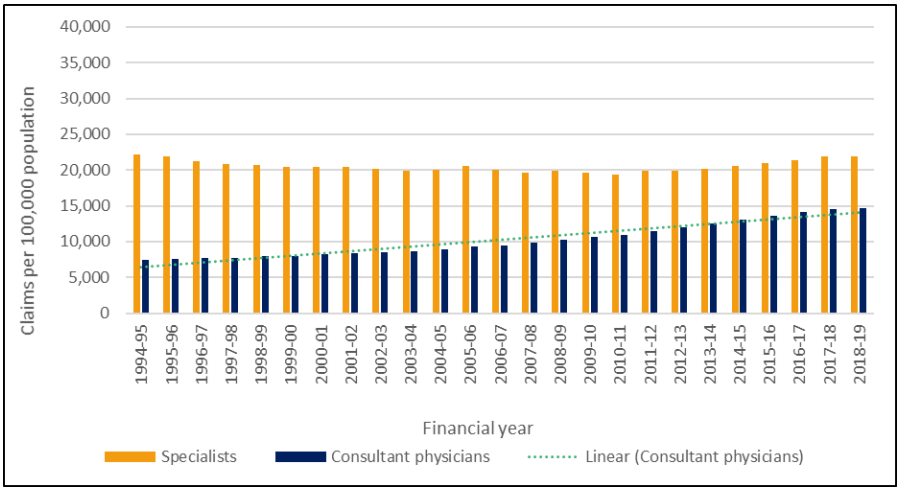
The presence of chronic and complex diseases and the need for long-term specialist care increases with age (AIHW, 2016). Consequently, the incidence of referral expiration will increase as the percentage of the population within this demographic grows in number (Commonwealth of Australia, 2015a).

COVID-19 and chronic disease

Emerging research indicates that patients infected with SARS-CoV-2 are susceptible to experiencing a range of post-infectious complications including lung scarring, neurological defects and cardiovascular disease (Ellul et al., 2020; Gupta et al., 2020; Nishiga et al., 2020). This 'post-Covid syndrome' will likely require long-term specialist care across numerous speciality fields, increasing the burden associated with referral expiration on both patients and the health system.

In 2018-19, the Australian Bureau of Statistics (ABS) Patient Experiences survey reported that more than 2.8-fold the number of people with a long-term health condition saw a specialist in the preceding year, compared to those without (ABS, 2019). Increases in initial (Figure 2.1) and subsequent (Figure 2.2) consultant physician attendance items remunerated through the MBS reflect this trend (Services Australia, 2020).

Figure: 2.1: MBS claims made for initial attendance items with a specialist or consultant physician.[2]



[2] Specialist claims data represents an aggregate of MBS item numbers 104, 107 and 113 and consultant physician data, an aggregate of MBS item numbers 110, 112, 114, 122 and 132. Item numbers represent the most common numbers for initial consultations billed in ambulatory care (including videoconferencing), excluding ophthalmic specialist consultations (Services Australia, 2020).

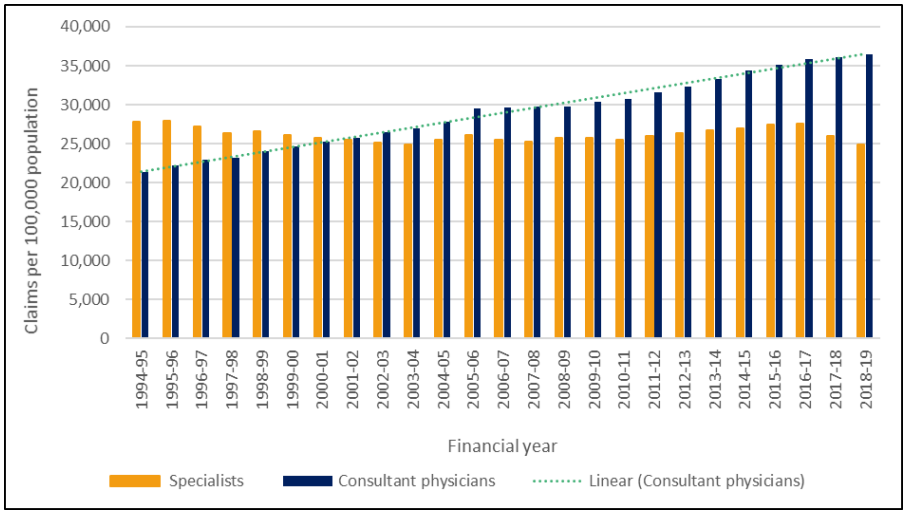


Figure 2.2: MBS claims made for subsequent attendance items with a specialist or consultant physician.[3]

Contemporary data on health service utilisation and the pathways patients take through the health system is often limited to particular service providers or short reporting timeframes. More consistent data on longitudinal health service utilisation trends across service providers and jurisdictions is needed to inform how services must be restructured and legislation adapted, to improve patient throughput.

2.2 *Single course of treatment and indefinite referrals*

A referral is valid for a chronological period as well as for a 'single course of treatment', which can endure beyond the referral's validity period (MBS Regulations, r 1.1.6). Due to the rise in chronic illness, referrals for a single course of treatment that extend beyond the standard 3-month validity period for specialist-issued referrals, or twelve-months validity period for GP-issued referrals, are likely to become increasingly common. As a result, more referrals will expire during the necessary course of treatment and any repeat referral issued is unlikely to change the care plan already established by the specialist. Resolving this issue requires a thorough review of the legislation and its impact on patient care, including the relationship between validity periods and the definition of a single course of treatment.

Moving towards a default indefinite referral system would prevent the need for repeat referrals to be issued during the single course of treatment and would promote health system efficiency.

[3] Specialist claims data represents an aggregate of MBS item numbers 105 and 108 and consultant physician data, an aggregate of MBS item numbers 116, 119, 128, 131 and 133. Item numbers represent the most common numbers for subsequent consultations billed in ambulatory care (including videoconferencing), excluding ophthalmic specialist consultations (Services Australia, 2020).

A **'single course of treatment'** includes the initial attendance, continuing management or treatment to the point the patient is referred back to the referring practitioner, and any subsequent review of the patient's condition that is deemed necessary by either the referring practitioner or the consultant physician (MBS Regulations, r 1.1.6). When the care received falls within the definition of a single course of treatment, only subsequent attendance items may be claimed for ongoing care beyond the initial consultation item.

A new single course of treatment will only be initiated if the referral validity period has lapsed, and the referring practitioner considers it necessary for the patient's condition to be reviewed, and the patient has not been seen by the specialist for more than 9 months (MBS Regulations, r 1.1.6). In this instance, specialists may claim an initial attendance item again.

2.2.1 Indefinite referrals by default

Different representative groups have expressed opinions relating to the use of indefinite referrals. The Royal Australian College of General Practitioner's (RACGP) discourages the use of indefinite referrals on the basis it 'can interrupt continuity of care and [a practitioners] capacity to provide ongoing care to the patient' and further suggest that referrals between 1 and 3 years are appropriate in most cases (RACGP, 2019b). However, referrals do not prevent specialists from otherwise keeping GPs informed of a patient's healthcare, nor do they prevent patients from consulting with their GP while receiving ongoing specialist care if that is the patient's preference or need.

Unless indefinitely issued, an initial referral to a specialist is highly likely to expire prematurely when issued prior to a diagnosis being reached or specialist care plan being established. This is particularly so for specialist-issued referrals that expire after 3 months despite many specialist treatments extending beyond this.

Existing patterns of health service utilisation highlight key issues with the referral system. These patterns help to explain why, for many patients, referral expiration often occurs during the 'single course of treatment' – further exposing how the requirement to obtain a repeat referral offers limited clinical benefit. For example, between 2018-19, 50% of patients on public surgical waitlists in Australia were admitted for surgery within 41 days, 90% within 279 days, and 2.1% waited more than 365 days (AIHW, 2018). These figures indicate that at least 15,921 people on a surgical wait list would have exceeded the standard twelve-month period of referral validity attached to GP referrals and would have needed a repeat referral prior to their surgery. If referrals were however originally provided by a specialist and therefore expired after 3 months, more than 50% of those wait listed, at least 189,534 people, would have needed to obtain a repeat referral while waiting for their planned surgery, even though the treatment formed part of a single course. In addition, the likelihood of a referral expiring while awaiting a surgical procedure is higher depending on where (geographically) the surgery is scheduled to occur and what clinical procedure is planned (e.g. orthopaedic or respiratory related) with periods of referral validity disproportionately impacting patients across the country. For example, residents in the Australian Capital Territory on the otolaryngology, head and

neck surgery wait list were much more likely to exceed the referral validity period in 2018-19. During this period half of those wait-listed waited more than 119 days for their surgery and almost 21% waited more than 365 days and were therefore highly likely to have required a repeat referral based solely on the previous referral's expiration (AIHW, 2018).

Any additional referral that must be issued as a result of the previous referral's expiration is considered a low value activity, given specialist care needs have already been established and specialist care has commenced (General Practice and Primary Care Clinical Committee, 2018). The CHF advocates for indefinite referrals by-default, stating that the '[a]nnual renewal of referrals is a complete waste of time and resources for healthcare [patients] and doctors. This is particularly so for someone with a chronic illness or a condition which has been treated and he or she is going back for periodic review' (Consumer Health Forum of Australia, 2015, pg9).

Giving specialists the ability to extend the period of a referral validity within a single course of treatment, in consultation with the patient's GP if required, would prevent the unnecessary issuing of repeat referrals that offer limited value to patients and the health system.

2.2.2 Single course of treatment billing practices

The single course of treatment model is predominantly designed around MBS billing practices and allows clinicians to distinguish between when it is appropriate for the specialist to claim the higher 'initial' rate versus the lower 'subsequent' rate. Ambiguity surrounding the interpretation of the single course of treatment rule in the context of expired and newly issued referrals has contributed to incorrect billing practices – exposing patients to increased out of pocket costs (Case study 1). This is because more initial consultations (remunerated at the high rate) are being claimed than is appropriate (RACGP, 2019c; Principles and Rules Committee, 2016).

Case study 1: Repeat initial consultation fees for ongoing care

'My specialist requires me to get a new referral annually and charges me for an initial consultation fee each time she reviews the same skin cancer… I should be able to go back to the same specialist annually under the original indefinite referral to review the same skin cancer and be charged only for a consultation fee (which is much less than the initial consultation fee). Each year I have to pay for a consultation with my GP for the referral and an initial consultation fee for the specialist' (Specialist and Consultant Physician Consultation Clinical Committee, 2018, pg29).

The Royal Australian College of Physicians (RACP) Chapter of Community Child Health, has noted that indefinite referrals are clinically worthwhile, though highlights issues surrounding how referrals are intwined with specialist billing practices:

"[i]ndefinite referrals are good in that you can keep seeing the patient without the patient having to go back to the GP for a new referral. This however will hamstring you into only claiming the 'Subsequent attendance' consultations (which have lower rebates) and cannot claim 'Complex consultations' (which attract greater rebates from Medicare) after the first 12 months of that referral" (Koh, 2014).

In response to anomalies in differential billing practices, the Principles and Rules Committee (2016) recommended abolishing differential billing and introducing time-tiered attendances in order to mitigate any billing confusion and misuse. This Committee suggested that more clearly defined terminology be used within the MBS Regulations to explain when a specialist can and cannot claim an initial consultation (Principles and Rules Committee, 2016). However, although it is a referral's expiration that gives rise to the opportunity to claim an 'initial' consultation item when a 'subsequent' claim is more appropriate, the relationship between the period of a referral's validity and MBS billing was not considered as part of that review.

Given that referrals should be based on clinical need, issuing indefinite referrals by default and decoupling specialist remuneration from periods of referral validity is needed to promote clinically driven practices. Removing referral expirations would prevent inaccurate billing practices and would remove the economic incentive of some specialists to refuse a valid indefinite referral when one is issued (Scott and Branley, 2014). Further, restructuring specialist MBS items to ensure they are based on clinical need, and not inextricably linked to referral periods will better promote high-value patient-centred care.

Dedicated strategies to educate service providers on MBS billing rules would ensure compliance and prevent inaccurate claims being lodged when care falls under the single course of treatment. The Principles and Rules Committee (2016) recommended that MBS Provider numbers be conditional on completing mandatory training. However, ongoing training is required to ensure provider understanding is maintained and this should also extend to administrators who most often lodge the claims on the specialist's behalf. The Principles and Rules Committee (2016) initially recommended the Colleges incorporate referral rules and MBS billing as part of continuing professional development requirements, but this was not a final recommendation to Government.

3 Referral expiration and the patients' healthcare burden

3.1 *Referral validity status, unexpected specialist costs and delayed care*

The Regulations do not specify whether it is the patient or clinician that carries the responsibility for monitoring a referral's validity status. Though specialist services may have procedures in place to notify a patient of their referral's expiration (Children's Health Queensland Hospital and Health Service, n.d), this is not a regulatory requirement. Accordingly, it is the patient who ultimately carries the burden of maintaining their referral's validity status if they are to receive the benefit of MBS subsidised treatment.

While patients, MBS providers and administrators alike often fail to understand the rules around referral validity and expiration, especially regarding the date the validity period starts to run (CHF, 2015; RACGP 2019c), it is the patient who is exposed to unplanned, out of pocket costs associated with specialist fees if a service is rendered without a valid referral being in place.

Issuing a 'backdated' referral to cover any period of referral invalidity is an offence under the Act, even though the care provided may have formed part of a single course of treatment (see Case Study 2).

While specialists benefit from legal protections which ensure they are not financially disadvantaged when patients fail to attend a consultation,[4] no similar provision exists to protect patients from incurring higher out of pocket costs if specialist services are rendered after a referral has expired.

Accordingly, legal protections for patients are needed to safeguard against costs associated with an expired referral. Further, a dedicated patient support and education service that provides accurate information on referral rules and responsibilities would promote better community understanding of the referral system and MBS rules and responsibilities more broadly.

Case Study 2: Backdated specialised referral

"…I was injured at a sporting event that ended up requiring surgery to fix up. After the accident I was transported to the local hospital via ambulance where I was treated well and given a referral to see a surgeon and some drugs. I then saw the surgeon who recommend surgery which all went well and after several follow-on appointments, I've been given the all clear to get back to activity."

"A few days after my last appointment I get a call from the surgeon's secretary informing me that the last surgeon's appointment was after the end date of the original referral. So, she asked me to go to a local doctor to get one that covered that date so they could claim the appointment through Medicare. All the surgery and stuff was done through private health insurance (and still ended up being bloody expensive)."

"So, I call my local GPs office and told them what was requested and they replied that they can give me a referral that covers from today onwards but can't give a backdated one as it is illegal. She also said that specialists should know this but sometimes still try and get one. So, I'm not really sure what I should do here. I'm worried that the specialist might charge me the full cost of the appointment" (Geeves, 2015).

For patients with chronic illnesses whose care may involve numerous specialists, the burden of tracking different referral expirations is cyclical and cumbersome. This is particularly the case when the referring practitioner issues fixed term rather than indefinite referrals; or the specialist rejects an indefinite referral (CHF, 2015; Scott and Branley, 2014). Again, this scenario disproportionately impacts more vulnerable patients such as older Australians, Aboriginal and Torres Strait Islander peoples, rural and remote residents and lower income earners who are more likely to experience chronic illness requiring long-term specialist care, yet are less able to pay for their increased medical costs (Jeon, et al., 2009).

In 2018, a CHF survey on medical out of pocket costs indicated that non-surgical related specialist expenses, especially costs related to out-patient consultations, were a key concern for 29.4% of patients (CHF, 2018). For some patients who took part in this survey, the annual out of pocket specialist expenses exceeded $5,000 a year and the apparent lack of transparency around specialists'

[4] Under Australian Consumer Law, private medical specialists (acting as businesses) are able to charge a cancellation fee if a Cancellation Policy is provided to patients upon initial engagement with their service.

costs exacerbates the burden to patients as they may be ill-prepared to cover unforeseen medical expenses should specialist services be provided after the referral expires (CHF, 2018).

In 2018-19, the ABS reported that 7.7% of those who needed specialist care delayed doing so on at least one occasion due to cost, and that this was more likely to occur for those with a long-term health condition (ABS, 2019). Given that an estimated 40% of the population are unable to put their income into savings, with 1 in 10 Australians having less than $90 spare in their bank account (O'Chee, 2020), and 1 in 8 Australians being unable to raise $2,000 in a week for an emergency (Centre for Social Impact and NAB, 2018) - any additional expense, such as that generated by a referral's expiration, has the potential to exacerbate financial hardships and contribute to delayed and discontinued care (CHF, 2018). This is in itself associated with reduced patient outcomes and increased long-term costs and should be avoided wherever possible (Jeon et al., 2009; RACGP, 2019a).

Unless indefinite referrals by default are introduced, relevant reforms must consider the responsibility of notifying patients of forthcoming referral expirations. Notification of pending referral expiration should be given in a reasonable timeframe to enable patients to better budget their time and money.

3.2 *Obtaining a repeat referral*

3.2.1 Face-to-face GP consultations

GPs issue an estimated 15 million referrals to specialists each year (Productivity Commission, 2017a). This number is likely a consequence of the increased demand for specialist care and restrictions around who can issue referrals. As the issuance of a referral itself is not billed under a unique MBS item number, and the service is absorbed into a broader generic consultation item number, it is unclear exactly what percentage of these 15 million referrals are for repeat referrals sought purely on the basis of the previous referral's expiration. However, given there were 9,323,644 'initial' consultations claimed by specialists in 2018-19[5], it can be inferred that at least 5,676,356 referrals were associated with continuing care (Services Australia, 2020).

If the same number of GP consultations occurred as a result of the regulatory need to obtain a repeat referral, the cost to the MBS in 2018-2019 is estimated to have been $219,958,795 million[6], excluding any bulk-billing incentives that may have also been claimed. Therefore, if the requirement of issuing repeat referrals for continuing care was removed, the likely savings to Government would be immense.

[5] Aggregate of MBS items 104, 107, 110, 112, 113, 114, 122, 132.
[6] Figures are based on item code 23, a standard level B GP consultation <20 minutes in duration which pays a benefit of $38.75.

For patients in 2018-19, 34.56% of GP consultations were not bulk billed and an average out of pocket cost of $37.62 per consultation was paid (Senate Community Affairs Committee, 2019). Therefore, out of pocket cost for patients to obtain repeat referrals via face-to-face GP consultations is estimated to be $73,800,984 million. For residents in rural and regional locations, the ACT and Tasmania with no or low bulk-billing rates, the costs to individuals would be much more (Senate Community Affairs Committee, 2019). Although high, this figure is likely a considerable underestimation of the true burden on patients given the indirect cost of attending consultations associated with workplace absenteeism, the time taken to attend consultations, the cost of travel and parking (Prime et al., unpublished), and the rise in full-fee 'on-demand' repeat referral service options provided by GPs (RACGP, 2017).

The indirect burden of illness: An example

The health system and family costs of chronic wet cough in Australia were evaluated in a study of 91 children referred to the Queensland Children's Hospital paediatric respiratory specialist outpatient department. During the average 22 months of data collection, families incurred 50% of the $1.9 million in total costs identified. Of this, 81% of family costs were associated with parental income loss due to caring for their sick child or attending medical appointments (Prime et al., unpublished).

The high burden, indirect costs should be included in any cost of illness evaluations and government discussion on the burdens and benefits of health service interventions, especially the referral framework and referral expiration, as this represents an ongoing cost to patients.

Given patients under specialist care are likely to have diverse medical needs, referrals may be obtained during a traditional face-to-face GP consultation in combination with another service. Between 2000-01 and 2015-16 there was a 2.8-fold increase in the number of referral requests which occurred in this manner (Britt et. al., 2016).

Although the need for a GP consultation based on referral expiration may hold a degree of 'hidden value' (Trevena et al., 2018) – as GPs are presented with an opportunity to provide additional services – the very nature of completing this task detracts from the time GPs have to provide more clinically beneficial care. Managing complex patient needs within the limited timeframe of a GP consultation leads to the 'prioritisation of conditions and treatments…frequent carry-over of management issues to subsequent consultations or failure to address conditions' (Harris et al., 2013). This can contribute to variability in the quality of care provided to patients, which then requires targeted strategies to improve patient outcomes and reduce the burdens and costs of illness (Prime, et al., 2018; Swerissen and Duckett, 2016; Commonwealth of Australia, 2015b).

The need for more accurate data on the number and type of appointments associated with obtaining a referral was identified during the development of AIHW's National Primary Health Care Data Asset (AIHW, 2019a). Moving forward, the AIHW should be supported to incorporate data into the Primary Health Care Data Asset that distinguishes between new and repeat referrals and the associated costs to patients and the MBS. This would allow for a better understanding of patient's needs and what changes are required in order to promote high-value primary care service delivery.

3.2.2 On-demand full-fee referral services

Full-fee on-demand referral services have emerged as an additional mechanism for patients who want to obtain a repeat referral (RACGP, 2017). These services do not require a consultation to take place between the patient and their GP, and are most commonly facilitated on-line, either direct from the practice, or via a third-party booking platform, for example HotDoc (HotDoc Online Pty Ltd, 2020a).

While such full-fee services are recognised as an opportunity for practices to increase revenue (RACGP 2017), when provided by a patient's regular GP or GP practice, this service can also offer a range of benefits, including:

- less time spent on routine administrative activities by the GP, freeing-up time for more clinically-driven consultations;
- reducing overall consultation wait-times;
- increasing access for those living remotely or with mobility issues; and,
- reducing costs for patients associated with transportation and time off work to attend face-to-face consultations (RACGP, 2017).

On-demand referrals do not attract an MBS subsidy, however the average cost to patients is lower than the out of pocket costs associated with standard face-to-face consultations (HotDoc Online Pty Ltd, 2020a; RACGP, 2017).

For example, a non-exhaustive review of QLD GP practice websites during April 2020 identified at least 49 individual practices that offered full-fee repeat referral services.[7] Of those who advertised their fees online, the average cost to the patients was $23 per referral (range $13-$50). This is compared to the average out of pocket cost of $37.62 to attend an MBS subsidised face-to-face consultation in 2018-19 (Senate Community Affairs Committee, 2019). Additional 'urgent' repeat referral services attracted a higher average out of pocket cost of $37 (range $25-$55).

These costs need to be taken into consideration in future evaluations of the referral system.

3.2.3 Telehealth and COVID-19

Temporary MBS telehealth items introduced in 2020 in response to the COVID-19 pandemic have increased access to GPs by decreasing the burden associated with attending face-to-face consultations (Bollen and Haddock, 2020). Embedding telehealth items into the MBS permanently would reduce the time required of both patients and GPs for basic administrative activities, including repeat referrals, therefore reducing patient and health service costs.

Telehealth consultations for referrals were due to be trialled as part of a voluntary patient enrolment (VPE) initiative announced in the 2019-20 federal budget. While this initiative was suspended due to COVID-19, the VPE aimed to improve primary care for those aged 70 years and over (or 50 years and over for Aboriginal and Torres Strait Islanders). Despite the lack of public

[7] Practices were randomly sampled from the internet on the 22 April 2020 after entering the following word into the Google search criteria: "*GP repeat referral*". This data is intended to be illustrative not exhaustive.

disclosure around its implementation strategy and associated costs, both to patients and to the MBS, it is likely that any of the benefits of the VPE model, so far as referrals are concerned, have temporarily been achieved through implementation of the COVID-19 telehealth items (AMA, 2020).

Some on-demand repeat referral services offered by GPs were suspended following the introduction of the special COVID-19 telehealth measures.[8] Given the MBS benefit for telehealth consultations is higher than the average on-demand referral fee, for example, $38.75 for item 91800 versus $23), and the fact that not all telehealth consultations must be bulk billed, GPs may be incentivised to limit their previous full-fee referral services in favour of telehealth referrals that now pay an MBS subsidy and potentially a gap-payment on top of this (Department of Health, 2020b).

Retention of MBS telehealth items for the general community beyond COVID-19 will help reduce the burden of referral expiration and the issuing of repeat referrals. Yet, in order to be affordable and accessible, this strategy should be bulk billed to reduce the burden on patients. Shorter capped consultation timeframes are also needed to reduce the burden on the MBS by remunerating GPs for the shorter consultation times needed to fulfil this service when performed in isolation.

4 Aligning referral practices with contemporary need

4.1 *GPs as more than gatekeepers*

A driving principle of the referral framework is that the GP should be the 'gatekeeper' to the broader health system (Principles and Rules Committee, 2016; RACGP 2019a). This model was, in part, adopted from the United Kingdom (UK), however no extensive review of its utility in the Australian context has been undertaken to date.

The gatekeeper model claims to have a range of benefits to the health care system, including being able to reduce the burden of demand on the limited number of specialists in Australia - who would otherwise be 'overwhelmed' by patients seeking direct specialist care for conditions that could feasibly be managed by a GP (Commonwealth of Australia, Parliamentary Debates, 1977). This scenario also purports to reduce health system costs associated with specialist care (Greenfield, Foley and Majeed, 2016).

However, the gatekeeping model has also been associated with delayed diagnosis and adverse health outcomes, including for example, early mortality amongst cancer patients who are prevented from accessing timely specialist care by GPs who did not recognise the early signs and symptoms of the disease (Hawkes, 2014). In addition, the percentage of gross domestic product (GDP) spent on

[8] For example: Balgownie Village General Practice which states on their website '[U]nfortunately due to COVID-19 this service has been temporarily stopped. Telehealth appointments can be booked with doctors if you need to obtain a script/referral only. Thank you'. Available from http://www.balgowniegp.com.au/repeat-referrals-and-scripts/

healthcare between those countries with and without the gatekeeping model is not significantly different, raising questions of its broader economic benefits (Greenfield, Foley and Majeed, 2016).

In Australia, a clear role for GP gatekeepers in the referral system, either for initial, expired, or repeat referrals, is largely unknown and should be evaluated in order to justify the considerable ongoing financial investment by patients and the health system in these roles. Such an evaluation is needed to inform the redesign of integrated healthcare that more adequately utilises the skills of the health workforce.

Reducing the administrative burden associated with referral expiration is likely to have positive benefits for the GP workforce. A national study of 1,935 GPs found that 12.1% of patient encounters resulted in non-billable time being spent on patient-related activities (Henderson et al., 2016). Of these encounters:

- referrals explicitly accounted for ~ 8% of non-billable time;
- discussing patient care with a specialist or allied health professional ~ 12% non-billable time
- unspecified administrative tasks, which may include referral related activities ~ 21.3% non-billable time (Henderson et al., 2016).

Non-billable time was independently associated with patients aged 65 years or older and those with one or more chronic health problem. These administrative activities were estimated to represent between $10,000 - $23,000 in non-claimed revenue per GP per year and are likely to contribute to the excessive workload experienced by 49% of GPs (Henderson et al., 2016; RACGP, 2019a).

In addition, a quarter of GPs report that their excessive workload prevents them from providing high-quality care and therefore there is a need to re-think how primary care is delivered, and what value, if any, repeat referrals have to patients and the health system (RACGP, 2019a).

The RACGP recognises that extended referral validity periods are unlikely to disrupt 'the principles of the centrality of GP care' but rather, would 'save unnecessary GP attendances and time spent on referring [by] GPs' (RACP, 2016, pg3). A move towards purposeful over opportunistic engagement is needed to alleviate any unnecessary burden on patients and GPs and prevent low-value government expenditure through the MBS.

Expanding referral pathways between non-GP clinicians, removing periods of referral validity or in the least, expanding validity timeframes to ensure they adequately cover contemporary health needs will help reduce the burden on GPs allowing for a greater focus on, for example, preventative healthcare and early intervention.

4.2 *Evidence-based and linear referral pathways*

Evidence-based clinical practice guidelines are tools to aid clinician decision making and provide recommendations on when, and to what speciality field a patient should be referred. The intent of such guidelines is to reduce the duration and severity of illness and improve patient quality and length of life (National Health and Medical Research Council, n.d).

Regulatory frameworks are however not routinely included in the formation of clinical guidelines. As a result, patients are placed in the middle of a system that attempts to promote clinical efficiency through evidence-based care yet is constrained by the Regulations in how this is achieved (Figure 3).

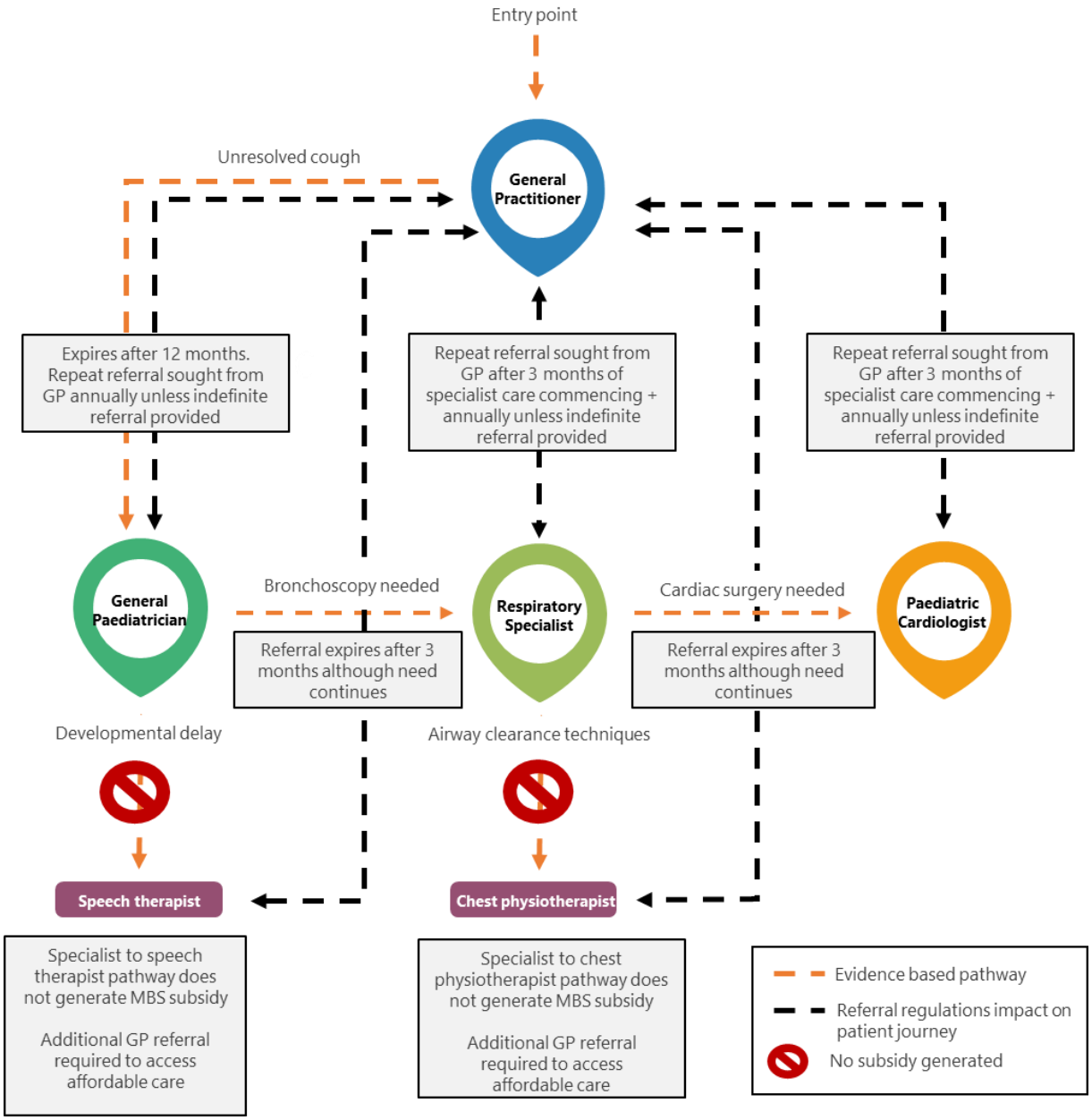


Figure 3: Impact of referral rules on the evidence-based[9] referral pathways for a child with a chronic respiratory illness and comorbidities

[9] Examples of clinical practice guidelines used within diagram: Queensland Health (2018); TSANZ (2014); Cincinnati Children's (2020); ACT Health (2018).

Reducing the number of transition points a patient must navigate through the health system by introducing and expanding the referral rights of non-GP clinicians is important for promoting health system efficiency - yet progress in this area has been slow (Leggat, 2014; Productivity Commission, 2015; Australian Health Ministers' Advisory Council, 2017).

For example, in 2005 the Productivity Commission recommended expanding referral rights between allied health practitioners and specialists. Thirteen years later, in 2018, similar recommendations were made to the MBS Review Taskforce (Productivity Commission, 2005; Specialist and Consultant Physician Consultation Clinical Committee, 2018; Allied Health Professions Australia, n.d).

Non-linear referrals were also recognised as a key issue by the Commonwealth of Australia (2016) during an inquiry into chronic disease prevention and management in primary care by the House of Representatives Standing Committee on Health. Issues surrounding the limited MBS subsidised referral pathways available to clinicians and patients' needs to be resolved by harnessing the skills of the non-GP workforce through expanded clinician referral rights. This would promote efficiencies in the way patients transition through the health system with care provided based on clinical, not administrative need.

4.2.1 Harnessing the skills of non-GP clinicians

Australians are supported by a diverse range of highly competent clinicians who are governed by rigorous professional conduct frameworks. Yet limitations within the referral system around referral rights have created unnecessary challenges and professional roadblocks by precluding certain clinicians from making specialist referrals or limiting the period of their issued referral's validity. These limitations prevent non-GP clinicians from utilising the breadth of their knowledge and skills by impacting their ability to refer patients to other services when it is deemed clinically necessary to do so (Productivity Commission, 2005).

The limited validity periods that do exist for nurse practitioners and specialists create unnecessary duplication within the health system by requiring repeat referrals be provided when the clinical need has already been determined and care commenced. In addition, the ideology that drives referral behaviours more broadly – GP centrality – had led to additional limitations being imposed on referral practices by clinicians. For example, in 2012 the South Australian Government had advised their medical workforce that:

"[w]here Emergency Department (ED) medical employees identify that a specialist outpatient appointment is required, the patient should be returned to the GP and the GP should instigate the referral. ED medical employees are to provide the GP with a letter outlining the type of specialist outpatient clinic required and the rationale for the outpatient appointment."

(Government of South Australia, 2012)

Between 2000-01 and 2015-16, approximately 1% of GP consultations were for the sole purpose of issuing a new referral (Trevena, et al., 2018). These encounters offer no additional benefit to patients and are purely an administrative activity that is likely a result of the non-linear referral

pathways and the requirement for patients to seek a specific referral for a need that has been pre-determined elsewhere. The cost of such appointments to the MBS under one standard GP consultation item code alone in 2018-2019, excluding any bulk-billing incentives, would have equated to an estimated $32,690,914.[10]

In order to achieve high-value service delivery, any deviation from linear referral pathways should be avoided and more attention needs to be given to the benefits of new models of service delivery beyond the traditional silos of GP-specialist frameworks (Mutsekwa et al., 2019). Allied health or nurse-first models of specialist care have been shown to reduce specialist outpatient wait-times and costs and improve patient outcomes and satisfaction (Saxon et al., 2018; Queensland Health, 2016). Under these types of initiatives, referrals to a specialist out-patient department are first assessed by, for example, a dietician or nurse who is supported to manage patients without initial specialist input, and identify and refer patients on to a specialist when additional intervention is required (Queensland Health, 2016).

It has been estimated that direct referrals by physiotherapists to specialists would save the MBS almost $14 million per year, and patients more than $2 million per year, in unnecessary GP visits (Australian Physiotherapy Association, 2015). However, if any new model of care is constrained by short periods of referral validity (for example, 3 or even twelve months), any cost saving associated with direct referral pathways will be largely artificial, as costs will simply be deferred to a later period of time when the GP provide the necessary repeat referrals upon the expiration of the initial referrals.

Adopting a linear approach to referrals would support patient access to MBS subsidised services no matter which health care professional identifies the need for specialised care in the first instance. Such a model is needed to ensure that the health workforce is optimised, and patients are not disadvantaged by limitations in a referral system that results in increased out of pocket costs and delayed care.

Any new referral pathway established under the referral rules must be supported by a period of referral validity that is of sufficient duration to ensure referral expiration does not occur during the necessary course of treatment.

4.2.2 Coordination of care and referrals

The role of the GP as the primary coordinator of care is cited as grounds for the retention of the current referral system (Specialist and Consultant Physician Consultation Clinical Committee, 2018). However, only 60% of patients who saw 3 or more clinicians in 2018-19 had their care coordinated by a GP, and the primacy of a GP within a multi-disciplinary team can fluctuate with clinical need and workforce availability (ABS, 2019). Despite the referral rules remaining unchanged for decades, many patients still do not benefit from effecive care coordination at all. In 2018-19, more than a

[10] Figures are based on the number of consultations processed by the MBS for item code 23 – a standard consultation item number. In 2018-19 there were 95,961,659 consultations billed under item code 23 at a cost of $3,623,323,779 to the health system.

quarter (28.1%) of those with long term heath issues under the care of multiple clinicians did not consider their care was coordinated (ABS, 2019).

The referral framework places considerable emphasis on the coordinator of care but more importantly than 'who' coordinates care, is that the care is in fact coordinated and contextually appropriate (Australian Health Ministers' Advisory Council, 2017, pg32).

For example, dedicated 'cancer care coordinator' roles have been established to adequately manage the complex needs of cancer patients (Clinical Oncology Society of Australia, 2015). In remote and isolated parts of the country, including in Indigenous communities, remote area nurses and nurse practitioners often assume the role as primary care provider and coordinator in the absence of a consistent and accessible GP workforce (National Rural Health Alliance, 2005).

The referral system imposes barriers on patients under different models of care and these nuances must be taken into consideration in future revisions of the referral rules to ensure the 'one-size fits all' approach to health care is not perpetuated. The National Strategic Framework for Chronic Conditions calls for renewed attention towards creating 'supportive systems' and the first phase of this strategy aims to improve the coordination of actions to reduce duplication and improve efficiency within health services (Australian Health Ministers' Advisory Council, 2017). Addressing inefficiencies within the referral framework is a tangible means of achieving these objectives.

4.2.3 Interoperable health services

Inadequate communication between clinicians involved in the care of one person is associated with poor health outcomes and increased costs to patients and the health system. This issue is more likely to occur for those with chronic illness and multimorbidity given the greater number of clinicians involved in care and working across numerous private and public facilities (Australian Health Ministers' Advisory Council, 2017). Overcoming this challenge requires a highly interoperable health system that supports real-time health information exchange to reduce duplication, ensure adequate follow up is provided, identify any gaps in care, and prevent any conflicts in treatment plans.

Given the referral rules were developed in a time when the methods of communication between clinicians were technologically limited, referrals served a predictable function of information sharing between specialists and GPs. However, despite digital technology having evolved considerably since this time, the referral framework in general, and referral expiration in particular, continues to be used as an essential tool facilitating communication between clinicians.

For example, in their report to the MBS Review Taskforce, the Specialist and Consultant Physician Consultation Clinical Committee (2018, pg74) noted that 'health outcomes are better when GPs are informed'. This was used as justification for retaining the 3-month specialist to specialist referral validity period. Precisely why referral expiration is necessary to ensure GPs are 'informed' was not articulated by the Committee in their report.

A more considered approach to facilitating GP awareness of a patient's broader health system movements and treatment plans, beyond that which an expired and repeat referral offers, is needed to improve patient outcomes and reduce health system inefficiencies (AIHW, 2019b).

Under the current referral rules specialist-issued referrals must include the name of the patients regular GP (Regulations, r 99(2)), however it is not a requirement that a copy of a referral be provided to that GP. There is also no law compelling when and how much information specialists are to provide to the named GP in return. This means that in the absence of an effective interoperable health system, the only mechanism to facilitate GP involvement in a patients (team) care relies on referral expiration.

Mandating routine information sharing between all clinicians within a patient's care team, including copies of referrals, will offset the over-reliance on the referral framework as a proxy mechanism of interprofessional communication.

Timely access to medical data is important, and yet by international standards, Australia's health data is poorly captured and poorly linked. Greater investment in integrated health technology is needed to improve the 'compatibility or interoperability of health data governance frameworks' (Productivity Commission, 2017b; OECD Health Ministerial Meeting, 2017).

The need to improve data-sharing between members of a care team was previously suggested by the Specialist and Consultant Physician Consultation Clinical Committee (2018) during the MBS review process but was not officially put forward as a recommendation. Adequate information sharing should be supported by a centralised real-time health information exchange platform that bridges health system, service and jurisdictional barriers to ensure patients can progress in their health journey unencumbered by the Regulations whilst still being supported by a well-informed clinical team (Figure 4) (Australian Health Ministers' Advisory Council, 2017).

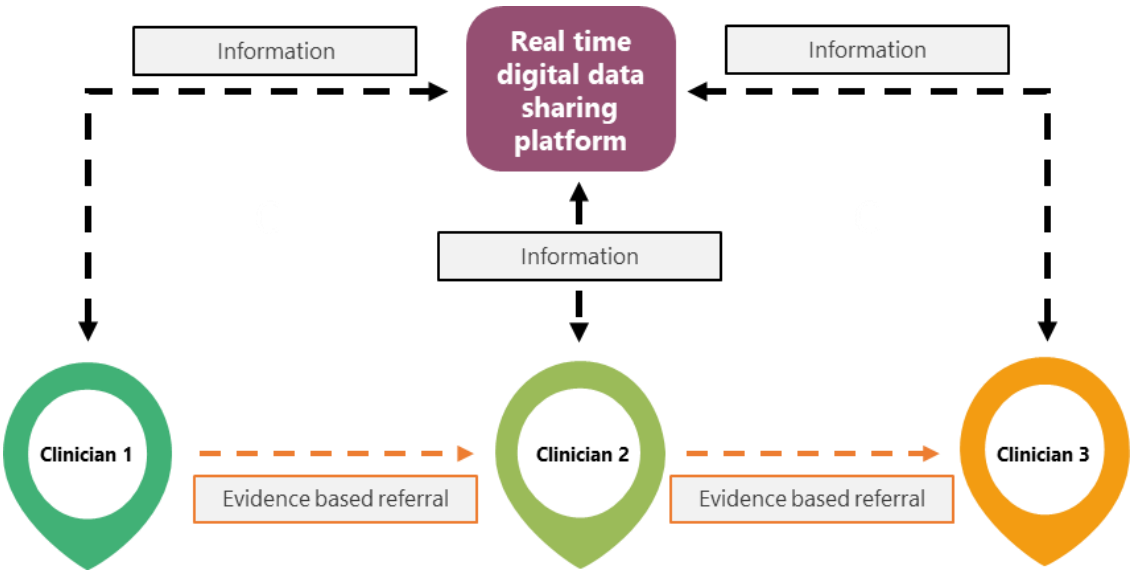


Figure 4: Linear referral pathways supported by an interoperable health care team

5 Conclusion and recommendations

The regulatory requirement for patients to obtain repeat referrals when already under the care of a specialist has received limited scrutiny since the 1970s. Using referral expiration as a means of triggering GP involvement fails to optimise the skills of the health workforce and burdens patients and the health system with regulatory-led GP engagement that offers low to no clinical benefit to patients. Moving towards a health service model that places a greater emphasis on the appropriateness of the referral above the profession of the referrer is necessary to bring the referral rules in line with contemporary health needs and service structures.

Achieving this requires a well-co-ordinated, effective and efficient referral system that facilitates the evidence-based and linear transfer of care from one clinician to another within a highly interoperable and collaborative healthcare system. The following recommendations are made to support improvements in the Australian referral framework:

5.1 *Recommendation 1: Implement a national strategy for capturing and reporting standardised referral-related metrics*

The limited data on how patients transition through the health system undermines effective service design. A national strategy for capturing and reporting standardised referral metrics is needed to inform evidence-based legislation and care. To be beneficial, this strategy needs to reflect referral trends across all sectors including public and private service providers. It should include detail on:

- the referral pathway/s taken by patients in order to access the necessary specialised care including who issued the initial and any repeat referral/s;
- the number of repeat referrals needed on an annual and lifetime basis in order to maintain affordable access to specialised care;
- the costs to the MBS associated with issuing initial and repeat referrals, and the costs to patients associated with obtaining initial and repeat referrals including full-fee referrals not subsidised through the MBS.

Including referral related metrics into the Primary Health Care Data Asset will improve knowledge gaps, however this also needs to be supported by an in-depth understanding of longitudinal trends in health service utilisation including tertiary related referral activities. A greater investment in linked data by government is therefore needed to ensure patient health service transition is adequately mapped and evaluated.

Incorporating referral related indicators into the Australian Health Performance Framework will support the continuous identification of areas in need of improvement based on patients evolving health needs, and provide an avenue for service comparisons and benchmarking in order to promote high quality integrated care and patient health service throughput efficiencies (The National Health Information and Performance Principal Committee, 2017).

5.2 *Recommendation 2: Conduct an independent, evidence-based review of the referral system*

An in-depth independent review of the health and economic costs and benefits of the referral rules, and associated MBS billing practices should be undertaken to ensure the rules that underpin referral practices are evidence-based, patient-centred and appropriate to support the changing health needs of the nation. The review should:

- consult widely with stakeholders (especially patients);
- draw extensively on data and research from within Australia - including MBS and non-MBS sources; and
- consider 'lessons learnt' from other countries, such as the benefits and barriers of GP gatekeeping, and the relevance of any findings within the Australian context.

In order to avoid issues surrounding physician conflicts of interest due to the association between referral rules and remuneration, it is recommended that this review not be physician-led. The review process and all evidence used to support any recommendations, should be transparent and easily accessible to patients, service providers, and governments.

Periodic review of referral legislation is recommended to ensure referral practices remain relevant and responsive to consumer needs and health workforce capabilities.

5.3 *Recommendation 3: Decouple specialist billing from referral status and introduce protections against increased costs for patients under long-term specialist care*

The expiration of a referral is broadly incompatible with the aims of specialist care for people with long-term illness. Indefinite referrals should be issued to ensure patients under long-term specialist care are not adversely and routinely impacted by referral expiration.

There is a need to decouple specialist billing more broadly from referral status to ensure consultations are based on clinical need. In the absence of such reforms, specialists and consultant physicians should be authorised to extend a referral when clinically appropriate in order to retain the referral's validity for MBS billing purposes.

In addition, civil and criminal penalties associated with backdating of referrals should be removed in circumstances where a period of invalidity coincides with a single course of treatment to ensure patients are not financially or clinically disadvantaged by referral expiration.

Should the Regulations and Act remain unchanged, introducing permanent bulk billed telehealth and on-demand referrals services for all Australians requiring repeat referrals would help protect patients from the burdens of obtaining repeat referrals for continuing care.

5.4 *Recommendation 4: Optimise the health workforce by expanding referral rights and adopting a linear evidence-based model of patient transfer through the health system*

All patients and especially those with complex illnesses and multimorbidity should not be financially disadvantaged or inconvenienced by the referral system based on 'who' identified the need for referral in the first instance. The current referral framework places a greater emphasis on processes over patients. Replacing it with one that is patient-centred, evidence-based, and adaptive to meet changing needs, is necessary to promote high quality and value-based care.

Expanding the referral rights, including periods of referral validity, for current and presently non-recognised clinicians under the MBS referral rules will maximise the skills of the diverse health workforce and reduce the frequency of unnecessary referral duplication.

5.5 *Recommendation 5: Establish a dedicated principles and rules function within the Department of Health to support the interpretation, implementation and routine revision of referral rules*

Without a dedicated service to monitor the appropriateness of the rules, and oversee the correct interpretation and application of the referral rules, patients will continue to be negatively impacted by outdated referral pathways leading to increased costs and delayed care.

A dedicated principles and rules function within the Department of Health should be established to:

- Support the widespread awareness of referral rules and responsibilities among patients to ensure they can exercise autonomy and self-determination within a patient-centred healthcare system.
- Develop public campaigns that educate patients on their referral rights, including the risk of liability for receiving specialist care under an invalid referral and what can be done to mitigate this risk.
- Support patients to effectively resolve referral related disputes and provide up to date advice on any changes to the referral system.
- Oversee the initial and ongoing training of MBS providers, administrators, practice managers and Medicare staff on the correct interpretation of the referral rules and MBS billing requirements.
- Investigate and mediate instances of the inaccurate interpretation of referral rules and improper billing practices.

5.6 *Recommendation 6: Invest in health service interoperability and mandate real-time health information exchange between multidisciplinary care teams to facilitate high quality, coordinated and continuous care*

Changes to the Regulation should be made to mandate timely information flow between all members of a patient's care team. This would reduce the burden on patients, and ensure GPs

remain informed irrespective of where the referral originates from; and alleviate any concerns over continuity and coordination of care raised by GPs.

Making better use of current digital platforms like My Health Record is recommended to ensure clinicians have near real-time access to detail on emerging patient issues and their transition through the health system (Australian Digital Health Agency, n.d). Referral management software such as the Queensland Health (2020) Smart Referrals platform should be made interoperable with larger interfaces, such as My Health Record, that can then serve as the national repository for all referrals made, irrespective of service provider or jurisdiction.

Referral platforms should facilitate a multi-way interface between all members of a patient's care team by providing up-to-date information on when a new referral has been made and consultation taken place. These systems could be enhanced through automation and built-in notification and alert functionalities that facilitate instantaneous updates for patients and service providers on nominated fields such as 'new referral issued' and 'referral expiring'. These notifications can then prompt GP follow-up if clinically necessary or facilitate a digital extension of the referral without the need for consultation.

6 Appendices

6.1 *Appendix 1: Stakeholder submissions to the MBS Taskforce Review*

Examples of stakeholder submissions to the MBS Taskforce Review against recommendations to retain 3-month period of referral validity attached to specialist-initiated referrals

Australian Healthcare and Hospitals Association

"[The] AHHA (2019) queries the rationale provided for limiting the validity of specialist to specialist referrals to 3 months. 'AHHA notes that the Committee identifies that this may be less convenient to patients but use the justification that the GP needs to maintain oversight (and cite evidence of improved patient outcomes). However, the Committee have not acknowledged the reality of wait times for accessing specialists, which vary significantly by specialist and geographically. Further, consideration does not appear to have been given to the duration required for adequate specialist treatment of a condition for which a patient may have been referred. Consideration should be given to extending the validity of referrals so that they are appropriate for the disease or condition and do not create an unreasonable or inequitable burden on patients. In response to a separate recommendation for time-tiered attendance items, the AHHA offered support but commented that monitoring is required to ensure 'referral validity periods do not impact on continuity of care with a specialist or consultant, nor create an unnecessary cost burden on patients". AHHA submission to the report of the Specialist and Consultant Physician Consultation Clinical Committee (AHHA, 2019)

Consumer Health Forum of Australia

"CHF is unable to support the recommendation…without a better explanation of the types of consumers who are currently disadvantaged by the 3-month limit." Response to the report of the Principles and Rules Committee (CHF, 2016, pg5).

"CHF's previous consultation in relation to the MBS Review reinforced a general lack of understanding of how the referral system works and a desire for some clarification and changes to make it more consumer friendly. The response from both the Principles and Rules Committee and this report to the referral issue is disappointing. Neither really addressed the issue of named referrals and the decision to keep the time limits on referrals does not address consumer concerns about unnecessary visits to the referring doctor when the condition is ongoing. Whilst the rationale for time limits is around continuity of care many consumers do not see it that way and raise issues around very perfunctory consultations to get the needed referral."

[..]

"The report is quite dismissive of "consumer convenience" in terms of needing to get referrals renewed. For many consumers, getting that renewal costs time and effort as well as an additional doctor fee if they are not bulk billed. For rural and remote consumers, it means travelling for appointments, with little or no financial support to undertake that travel. It would have been helpful

if the recommendations on telehealth later in the report included referral renewal consultations." Response to the report of the Specialist and Consultant Physician Consultation Clinical Committee (CHF, 2019, pg8).

Palliative Care Australia

"PCA acknowledges that the Committee has accepted the recommendation of the Principles and Rules Committee which has erred on the side of retaining the 3 month validity period for specialist referral to enable GP oversight of patient care provided by consultant physicians. However [sic] this is often problematic due to the delay in obtaining appointments for some clinicians, where the 3 month referral period can be very short and doesn't always allow for an initial referral and necessary review" (Palliative Care Australia, 2019, p. 7).

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