Consultation Paper
Modernising Referral Pathways

1. Purpose of this Paper

This paper seeks advice from patients, medical providers and other interested parties on whether current Medicare referral arrangements are effectively supporting access to specialist care for patients and makes suggestions for reform.

2. Scope of this Paper

This paper focuses primarily on referral pathways between general practitioners (GPs) and non-GP specialists, as well as from one non-GP specialist to another.

The Australian Health Practitioner Regulation Agency recognises GPs as specialists, while the terminology used in the MBS uses the term "general practitioner" as defined in the *Health Insurance Act 1973*. The *Act* similarly makes a distinction between specialists and consultant physicians, with specialists and consultant physicians billing different MBS items for various attendances and procedures. However, there is no distinction between specialists and consultant physicians in relation to referral arrangements. As such, for the purposes of this Consultation Paper, specialist general practitioners are referred to as GPs, while "non-GP specialists" refers to both specialists and consultant physicians unless otherwise indicated.

3. What are medical referrals and how do they work?

A medical referral is a written request from one medical practitioner to another for investigation, advice or reassurance, treatment or management of a patient's condition.[1] Referrals may come in the form of a hardcopy letter but can also be provided by fax or digitally via email or internal referral system. A medical *referral* is distinct from a pathology or diagnostic imaging *request*. The legislative requirements for requests are different to those for referrals and are not being examined for reform in this Consultation Paper. However, potential reforms to referral arrangements, (including digital capabilities), may also benefit patients accessing pathology or diagnostic imaging. There may also be value in adopting legislative requirements already established for pathology requests, such as standardised forms, for referrals.

In Australia, referrals are most often issued by GPs to other providers such as non-GP specialists, allied health practitioners and mental health service providers. GPs are generally the first point of contact for patients seeking health care; they are responsible for providing and coordinating care and operate.[2] Approximately 10% of GP attendances result in referrals to non-GP specialists.[3]

The referral process involves the partial transfer of responsibility for a patient's care, normally for a defined period and for a particular reason.[4] In theory, following that period or once the course of treatment has been completed, the patient returns to their original doctor or health professional for continued care. To be valid, a referral must include certain minimum information including the reasons

[1] MBS Online, Note GN.6.16

[2] Wright and Brell (2023), Balancing care and responsibility: The role of the general practitioner in specialist referrals - AJGP, p.843; Swerissen and Duckett (2018), Mapping primary care in Australia - Grattan Institute, p.7 & 14

[3] Ibid, p.16

[4] Ahpra (2020), Medical Board of Australia - Good medical practice: a code of conduct for doctors in Australia, p.16

for referral, it must be provided in writing and be signed and dated by the referring practitioner.[5] The purpose and intent of the referral must be clear to the receiving practitioner.

Although patients are not legally required to have referrals to see private non-GP specialists, these are necessary if patients wish to access referred MBS item benefits for services provided by these non-GP specialists, which attract much higher rebates than their non-referred counterparts.[6] There is therefore a strong incentive for patients to seek referrals from their GP if they require private specialist medical care as these may significantly reduce their out-of-pocket costs.[7] Additionally, some non-GP specialists may not offer attendances to patients without referrals.

Besides GPs, there are a limited number of other providers who can issue referrals to non-GP specialists under the *Health Insurance Regulations 2018 (Regulations)*, such as nurse practitioners. These providers have more restricted referral powers than GPs. The rules around default referral validity periods also vary depending on who is making the referral. A referral validity period starts on the date the first service is rendered under the referral, not on the date the referral is written.[8]

4. Potential issues with current referral rules

4.1 Understanding referral pathways

Many patients are unfamiliar with the rules around referrals, including who can issue them, how they can be used and what their rights are. Up to 60% of Australians have low health literacy, which includes difficulty understanding and using health information to navigate services like referrals.[9] Patients usually rely on their GP to recommend a non-GP specialist when they require specialist medical care.[10] GPs frequently refer patients to non-GP specialists that they have previous experience or familiarity with.[11] They also consider a range of other factors to ensure the patient will receive appropriate care such as clinical skill, quality of communication and compatibility, and patient convenience and preferences.[12] [13] However, GPs often lack access to real-time data on non-GP specialist availability, fees and quality indicators. This means that at the point of referral, patients are often missing vital information to support informed decision-making around their care.

Referrals from GPs often include the name of a specific non-GP specialist. The naming of a specific provider in a referral however does not usually prevent a patient from seeing a different non-GP specialist in the same field as that provider.[14] Medicare allows patients to claim MBS referred attendance items from any non-GP specialist in the same discipline as the practitioner named on the referral, regardless of whether the referral is made out to a specific named practitioner, or just to the name of a specialty.[15] Many patients are not aware of this flexibility, resulting in the misconception that

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[5] ss98, 99 *Health Insurance Regulations 2018* (Cth)

[6] Non-GP specialists are able to bill MBS items from item group A2 (Other Non-Referred Attendances To Which No Other Item Applies) for consultations with patients without a referral.

[7] Prime, Gardiner and Haddock (2020), Optimising health care through specialist referral reforms, p.5

[8] Department of Health, Disability and Ageing, AskMBS Advisory (2021), Non-GP specialist and consultant physician services, p.3

[9] Australian Commission on Safety and Quality in Health Care (2014), Health Literacy: Taking action to improve safety and quality, p. 2

[10] Finn et. al (2022), How Referring Providers Choose Specialists for Their Patients: a Systematic Review, p.3444

[11] Pascoe et. al (2013), Patients' experiences of referral for colorectal cancer, p.3-4

[12] Department of Health, Disability and Ageing, A guide for GPs – referrals to medical specialists

[13] Piterman and Koritsas (2005), Part II. General practitioner–specialist referral process, p. 493

[14] A Medicare-eligible public patient can choose to be treated as a private patient at a public hospital outpatient department if they have a referral to a named specialist exercising a right of private practice as per subclause G19(b) of the National Health Reform Agreement.

[15] Ibid.

a patient who is unhappy with the practitioner named on their referral must go back to their GP to get a new referral. This issue can be further exacerbated when a patient is not given a copy of their referral, such as when the referring GP provides the referral directly to the named non-GP specialist or through the practice's electronic clinical software system without ensuring the patient has access to a copy. Without easy access to their own referrals or an understanding of how they work, patients are limited in their ability to "shop around" for a non-GP specialist with lower fees or shorter waiting periods than the one recommended by their GP.

Care coordination following referral can also be problematic. Some non-GP specialists report inadequate information in GP referrals, and some GPs claim they often receive little or inadequate feedback from non-GP specialists on the treatment their patients receive.[16] While there are requirements specifying the content that must be included in referrals, there is limited guidance and no enforceable requirements on the information the referee should report back to the referring GP.[17] The current referral system may therefore be limiting effective information sharing between GP and non-GP specialist providers.

4.2 Referral validity periods

While GPs can issue referrals for any length of time under the *Regulations*, the default period is 12 months, and non-GP specialist-to-non-GP specialist referrals expire after three months.[18] Both referral periods commence from the date of the first specialist attendance – not the date the referral was issued.

These validity periods have been criticised for not aligning with contemporary healthcare needs. The Deeble Institute for Health Policy Research argues that the current referral system is outdated and was designed to support management of acute illness, not chronic and complex conditions which are increasingly prevalent.[19]

Effective treatment of chronic conditions may require ongoing non-GP specialist care. However, patients with 12-month referrals must return to their GP for renewals even when their condition is unchanged, causing inconvenience and potentially extra costs. The Consumer Health Forum's 2025 Budget Submission noted that consumers are frustrated by costly and inflexible referral processes.[20] For the GP, this renewal process can help keep them informed and involved but can also add administrative burden and additional service provision where there may not be a need.

The three-month non-GP specialist-to-non-GP specialist validity period has historically been used as mechanism to ensure the GP coordination and gatekeeper role is maintained. This short referral period encourages patients to visit their GP to obtain longer referrals, thereby guaranteeing the GP is updated on their condition. However, referrals from one non-GP specialist to another have become increasingly common for a variety of reasons, such as to expedite patient access to another specialty or in the management of conditions that require oversight by multiple specialists (e.g. cancer). The short validity period of these referrals often means they expire before a patient's non-GP specialist treatment is complete. As a result, patients must obtain repeat referrals, which can interrupt the continuity of their non-GP specialist care and add costs to their treatment. [21]

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[16] Swerissen and Duckett (2018), Mapping primary care in Australia - Grattan Institute, p.41

[17] MBS Online, Note GN.6.16

[18] The exception to this rule is for non-GP specialist-to-non-GP specialist referrals for a patient who is a patient in a hospital, in which case the referral is valid for the length of the patient's admission.

[19] Prime, Gardiner and Haddock (2020), Optimising health care through specialist referral reforms, p. 9-11

[20] Consumer Health Forum (2025), Federal Budget 2025-26 submission, p. 7-8

[21] Medicare Benefits Schedule Review Taskforce (2020), Taskforce final report – Specialist and Consultant Physician Consultation Clinical Committee, p.64

4.3 *Single course of treatment*

Referrals are generally valid for a single course of treatment involving an initial attendance by a non-GP specialist and the continuing management/treatment up until the patient is referred back to the care of the referring practitioner.[22] In circumstances where a referral expires while the course of treatment is still in progress, patients must return to their GP and ask for a new referral to enable the course of treatment to continue. Multiple courses of treatment cannot occur within the course of one valid referral.

4.3.1 Incorrect billing

A non-GP specialist attending to a patient for their first appointment relating to a single course of treatment is able to bill an MBS item for an initial attendance, which has a higher benefit compared to MBS items for subsequent attendances. The higher benefit paid on initial attendances reflects the understanding that these attendances usually take more time and may have more complexity than subsequent attendances. However, an initial attendance can only be claimed when a patient is beginning a new course of treatment. This means that where continued treatment of a patient's condition previously treated under a prior, now-expired referral is necessary, an initial attendance usually cannot be claimed even where the patient has obtained a new referral.[23]

The rules defining a 'single course of treatment' are set out in c 1.1.6 of the *Health Insurance (General Medical Services Table) Regulations 2021* (*GMST*). Despite this, there has been commentary that some non-GP specialists may be using the commencement of a new referral to claim an initial attendance item again.

One exception to this rule also comes from c 1.1.6 of the *Health Insurance (General Medical Services Table) Regulations 2021*, which outlines that the usual rule on the continuation of a course of treatment across multiple referrals does not apply if the referring practitioner considers it necessary for the patient's condition to be reviewed and that patient has not seen their non-GP specialist for 9 months or more. This results in the commencement of a new course of treatment, where the treating non-GP specialist *can* claim an initial attendance item.

In a 2016 Report, the MBS Review Taskforce found excessive billing of "initial" attendance items by non-GP specialists, partly due to confusion over whether a new referral permits an initial attendance claim and partly due to the higher fees for initial items creating an incentive to claim them.[24] The Taskforce found that in 2013-14, 4.5% of patients who had a new referred initial attendance by a non-GP specialist had another initial attendance item billed by the same non-GP specialist within 12 months, increasing to 10.7% of patients in an 18-month period. For consultant physicians, these figures are slightly higher at 5.0% and 10.7% respectively.[25]

With the exception of patients attending the same non-GP specialist for an unrelated new issue or a change in a previously stable condition that prompted the referring practitioner to seek a review, patients who were billed multiple initial attendance items may have been better served by accessing subsequent attendance items under a longer referral. MBS data in FY 2024-25 showed that initial non-GP specialist attendances (excluding consultant physicians) averaged $154.63 out-of-pocket compared

[22] MBS Online, Note GN.6.16

[23] The exception to this rule is MBS items for psychiatrists, where there are specific items which are claimed for new patients (or patients who haven't attended the psychiatrist in more than 24 months). The benefit payable is time dependent, with longer consultations paying higher benefits.

[24] Medicare Benefits Schedule Review Taskforce (2016), First report of the MBS Principles and Rules Committee, p.15

[25] Medicare Benefits Schedule Review Taskforce (2016), First report of the MBS Principles and Rules Committee, p. 16

to $98.61 for subsequent attendances. These figures are similar for consultant physician attendances, where initial attendances averaged an out-of-pocket cost of $148.84 compared to $91.47. As a result, patients who are billed multiple initial, rather than subsequent, MBS attendance items may be financially disadvantaged compared to if they were billed a subsequent attendance item, in addition to the extra time and potential cost required to attend an appointment with a GP to obtain a new referral.

4.3.2 Second opinions or change of practitioner and named referrals

Patients can initially take a referral to any non-GP specialist in the same discipline as the practitioner named on the referral, giving flexibility in choice of practitioner. This rule applies regardless of whether the referral is made out to a specific named practitioner, or just to the name of a speciality.[26] However, once any practitioner has rendered a service under a referral, it cannot be used to see additional practitioners. If patients are dissatisfied and wish to see other practitioners about the same condition, they must obtain a new referral for each one, creating inconvenience and extra costs.

Currently, taking a referral to a new practitioner after a non-GP specialist has already rendered a service under that referral constitutes the beginning of a new course of treatment. As a referral is not valid for multiple courses of treatment, the patient must acquire a new referral to access services from another practitioner. This means patients must obtain an additional referral from their GP to continue their treatment under a new practitioner, despite no change in their condition, and the original referral remaining valid for use with the originally seen specialist. Patients must therefore either elect to continue treatment with a non-preferred practitioner or incur the time and potential additional out-of-pocket costs obtaining a new referral from their GP.

5. Proposed approach to medical referral reforms

5.1 More informed consumers and clinicians

The department is seeking views on reform opportunities to improve consumer, practitioner and practice staff understanding of referral pathways and ensure patients are empowered to make informed decisions about their non-GP specialist medical care.

The Government has announced significant upgrades to the Medical Costs Finder (MCF) website to provide patients with greater information about the costs of medical services and individual non-GP specialist fees. The Government could also mandate that all referrals contain standard information about how referrals operate and where consumers can obtain more details, including about non-GP specialist fees (with a link to the MCF website) and informed financial consent rights. This could appear, for instance, as a disclaimer at the bottom of a referral letter issued by a GP. A similar measure already applies to pathology requests featuring a pathology provider's brand name, which must include a statement informing the patient that the request may be taken to a pathology provider of the patient's choice.[27] To ensure patients have access to this information, the Government could also mandate that patients are provided with a copy of the referral and the non-GP specialist reports on their condition, either as a hard copy/through email and shared with the patient's My Health Record.

The Government is already working to increase the sharing of health information between different parts of the health care system. In February 2025, the Australian Parliament passed the Health Legislation Amendment (*Modernising My Health Record – Sharing by Default) Act 2025.* Under this new

[26] Patients who present at a public hospital outpatient department who wish to be treated as a private patient by a specialist exercising rights of private practice must be in possession of a specifically named referral as per clause G19 of the National Health Reform Agreement.

[27] s 69 *Health Insurance Regulations 2018* (Cth)

law, certain healthcare providers must upload key health information to My Health Record, starting with pathology and diagnostic imaging providers. These requirements are scheduled to come into place in July 2026. Extending Sharing by Default requirements in the future to additional types of health information**,** including referral information could be considered.

These reforms align with the ongoing development of related national digital health capabilities that will connect all parts of the health and care economy to support consistent sharing of health information and digital referral pathways. These digital improvements could reduce the need for strict referral validity periods to enforce a minimum level of communication between GPs and non-GP specialists.

5.2 Referral validity periods that reflect contemporary health needs and services

The department is seeking views on reform opportunities to better align referral validity periods with contemporary health needs and services.

The Government could revise the default period for medical GP-to-non-GP specialist referrals from 12 months to either a longer fixed term (e.g. two or three years) or an indefinite period.

A similar extension to referral validity periods could be considered for non-GP specialist-to-non-GP specialist referrals, in recognition of the increasing role non-GP specialists play in coordinating patient care in modern medicine. Currently, referrals from one non-GP specialist to another are limited to a validity period of three months, with no option for the referring non-GP specialist to specify a longer period. The Government could provide non-GP specialists with greater autonomy to determine an appropriate referral length. Alternatively, the Government could set a longer maximum validity period – for instance, 6 or 12 months. This would give patients, particularly those with complex chronic conditions, sufficient time to complete testing, diagnosis, and treatment before referral expiry. An indefinite referral period could also be considered.

It is worth noting that expansion of the three-month validity period for non-GP specialist-to-non-GP specialist referrals has previously been considered by the MBS Review Taskforce. In 2020, the Taskforce considered but did not support the recommendation of the Specialist and Consultant Physician Consultation Clinical Committee to amend the validity period from three months to six months to minimise referrals that expire before treatment is finished. The Taskforce cited the need to preserve the central role of the GP in patient care coordination as the reason for retaining the shorter validity period.[28] However, the Deeble Institute for Health Policy Research argues that using the expiration of a referral to elicit GP involvement is opportunistic and provides limited clinical benefit.[29]

Regardless of referral length, once a patient is referred for non-GP specialist care, the non-GP specialist is responsible for managing treatment and communicating critical developments to other involved practitioners, including the patient's GP, if they have one. If referral lengths are extended, there are levers available to ensure the GP gatekeeper role is preserved. For instance, the Government could add requirements for non-GP specialists to notify a patient's GP/referring medical practitioner when there is a change in treatment or medication.

5.3 A clearer definition of a single course of treatment

5.3.1 Increasing the default validity period for referrals

Making referrals indefinite by default may reduce confusion around "a single course of treatment" and improve billing practices. Under this model, patients would no longer need to seek a new GP opinion

[28] Medicare Benefits Schedule Review Taskforce (2020), Taskforce final report – Specialist and Consultant Physician Consultation Clinical Committee, p.64

[29] Prime, Gardiner and Haddock (2020), Optimising health care through specialist referral reforms, p. 3-4

and referral for a condition within the same course of treatment, therefore removing the question about whether their practitioner should bill an initial or subsequent attendance. This would financially benefit the patient, who would no longer need to potentially pay to receive a new referral from their GP, and would be less likely to need to pay higher out-of-pocket costs for an "initial" attendance with the same non-GP specialist they have already been receiving treatment from. This may also reduce administrative burden on GPs, allowing them more time to focus on providing patient care.

Alternatively, the default validity period for GP to non-GP specialist referrals could be changed from 12 months to a longer fixed period, such as 24-months. Adopting such an approach would avoid modification to the current model for billing initial and subsequent attendances based on what constitutes a single course of treatment.

5.3.2 Considering the need for the 9-month initial attendance rule

If an indefinite validity period was adopted and the 9 month initial attendance rule was not modified, the rule would apply only where a patient acquires a new referral (in addition to the referring practitioner considering the commencement of a new course of treatment to be necessary), which would occur less frequently if referrals became indefinite by default. This may decrease instances of situations where there is provider confusion about whether an initial or subsequent attendance item is appropriate to bill.

The department is seeking views from consumers and sector stakeholders on the necessity of this rule should an indefinite referral model be selected, and whether there is a clinical need for patients who have not seen their practitioner for more than 9 months to be billed an initial MBS attendance item.

In the context of a potential shift to indefinite referral arrangements, this rule could also be removed so that initial attendance items are billable only at the commencement of a new course of treatment and issuance of a new referral. This is a simpler arrangement which may increase billing compliance.

5.3.3 Second opinions and change of practitioner

The inability of patients to take their referral to a new practitioner after a service has been provided by another practitioner could be addressed by modifying legislation to explicitly permit the continuation of treatment under a different practitioner under one referral, and for each practitioner to be entitled to bill an initial attendance item when they first see the patient. However, without further legislative changes, patients in this scenario would be unable to be billed an initial attendance item by the second non-GP specialist due to the lack of a new referral.

Given that the second non-GP specialist would be required to treat the patient as if this was their first attendance, a modification to allow the claiming of initial attendance items in such a situation may be reasonable. This would allow patients to seek second opinions without the inconvenience and potential financial costs associated with acquiring a new referral, and without disadvantaging the new non-GP specialist by preventing them from claiming an initial attendance item.

6. Conclusion

This Consultation Paper has sought to demonstrate how Medicare referrals currently operate, highlight some of the potential issues with these rules and put forward potential reforms to improve them. These changes are being considered as part of a broader plan to improve access and affordability of non-GP specialist medical services.

We invite you to provide your views on modernising referral by completing our online survey on Consultation Hub and to submit any additional written comments via email to

specialistaffordability@health.gov.au with the subject line “Modernising Referral Pathways – Additional Comments”. Submissions close on **6 March 2026**.

Thank you for your interest in this important matter.

General Consultation Questions:

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?

1. The current referral process makes it easy for patients to access specialist care.
2. Common referral validity periods (12 months for GP referrals, 3 months for specialist-to-specialist referrals) meet health needs.
3. Longer or indefinite referral validity periods would improve patient experience and reduce unnecessary costs.
4. Patients should always receive a copy of their referral.
5. Including cost information and links to Medical Costs Finder on referrals would help patients make more informed financial decisions.
6. Patients should be able to switch specialists under the same referral without needing a new referral.
7. 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.

Other multiple-choice questions:

8. For GP to non-GP specialist referrals, which validity period do you think would be most appropriate (e.g. 12 months, 24 months, indefinite or another period?)
9. For non-GP-specialist to non-GP-specialist referrals, which validity period do you think would be most appropriate (e.g. 3 months, 12 months, 24 months, indefinite or another period?)

Open response questions:

10. What risks or challenges do you foresee with making referrals longer or indefinite by default?
11. What do you foresee slowing or stopping the take up of a future Australia wide digital referral process?
12. Are there any other issues related to referrals that have not been captured in this consultation paper?
13. Are there any alternative policy options that you would recommend that have not been discussed in this consultation paper?

Consultation Questions for Consumers:

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?

1. I understand how medical referrals work and what my rights are when being referred.
2. I usually receive a copy of my referral.
3. Having access to my referral helps me make informed decisions about my care.
4. When bringing a referral to a non-GP specialist, I feel that they read and use the information included in my referral to provide the best care for my condition.
5. Standardised information on referrals (e.g., how they work, links to Medical Costs Finder) would help me make better decisions about my treatment.

6. I find it inconvenient to obtain new referrals for ongoing treatment.
7. The current referral process supports timely access to second opinions from non-GP specialists.
8. I rely solely on my GP's recommendation in deciding which non-GP specialist to see.

Open response questions:

9. What changes would make the referral process more convenient for you?
10. What information would you like to see communicated between GPs and non-specialist GPs regarding your care?

Consultation Questions for Referrers:

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?

1. I usually provide my patients with a copy of their referral.
2. Current referral rules support timely and coordinated patient care.
3. Patients attending appointments with me just for renewal of a referral is common.
4. I provide my patients with indefinite referrals where clinically appropriate.
5. Referral renewals for the management of ongoing conditions add unnecessary administrative burden to my practice.
6. Longer or indefinite referral validity periods would reduce my workload.
7. I would be comfortable with indefinite referral periods
8. If referral periods are extended, additional safeguards such as mandatory reporting to GPs by non-GP specialists are needed to maintain the GP's role in care coordination.

Open response questions:

9. What measures do you think should be required to maintain the GP's gatekeeper role if referral validity periods are extended?
10. What additional measures would improve communication between GPs and non-GP specialists?
11. 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?
12. What specialty do you practice in?

Consultation Questions for Referees:

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?

1. I usually update the referring doctor on the treatment of a patient's condition throughout the course of their treatment.
2. 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 my patients.
3. Referrals generally contain enough information for me to provide appropriate care.
4. Rules around billing initial versus subsequent attendances are clear.

Open response questions:

5. 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?
6. What safeguards should be in place to ensure adequate communication between non-GP specialists and GPs if referral periods become longer or indefinite?
7. Is there any information frequently missing from referrals, which would be important to provide appropriate care?
8. 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?
9. What specialty do you practice in?

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?

1. Consumers understand current referral arrangements, including who can issue them, how they can be used, and what their rights as patients are.
2. Referrals currently contain enough information for non-GP specialists to provide appropriate care.
3. 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.
4. Extending referral validity periods would better support patients with chronic and complex conditions.
5. Rules around billing initial versus subsequent attendance items are clear.
6. 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.

Open response questions:

7. What measures do you think would improve patient understanding of referral arrangements?
8. 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?
9. 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?