ANZCA
FPM

Australian Government Department of Health, Disability and Ageing

MODERNISING REFERRAL PATHWAYS CONSULTATION PAPER

Australian and New Zealand College of Anaesthetists (ANZCA) consultation response

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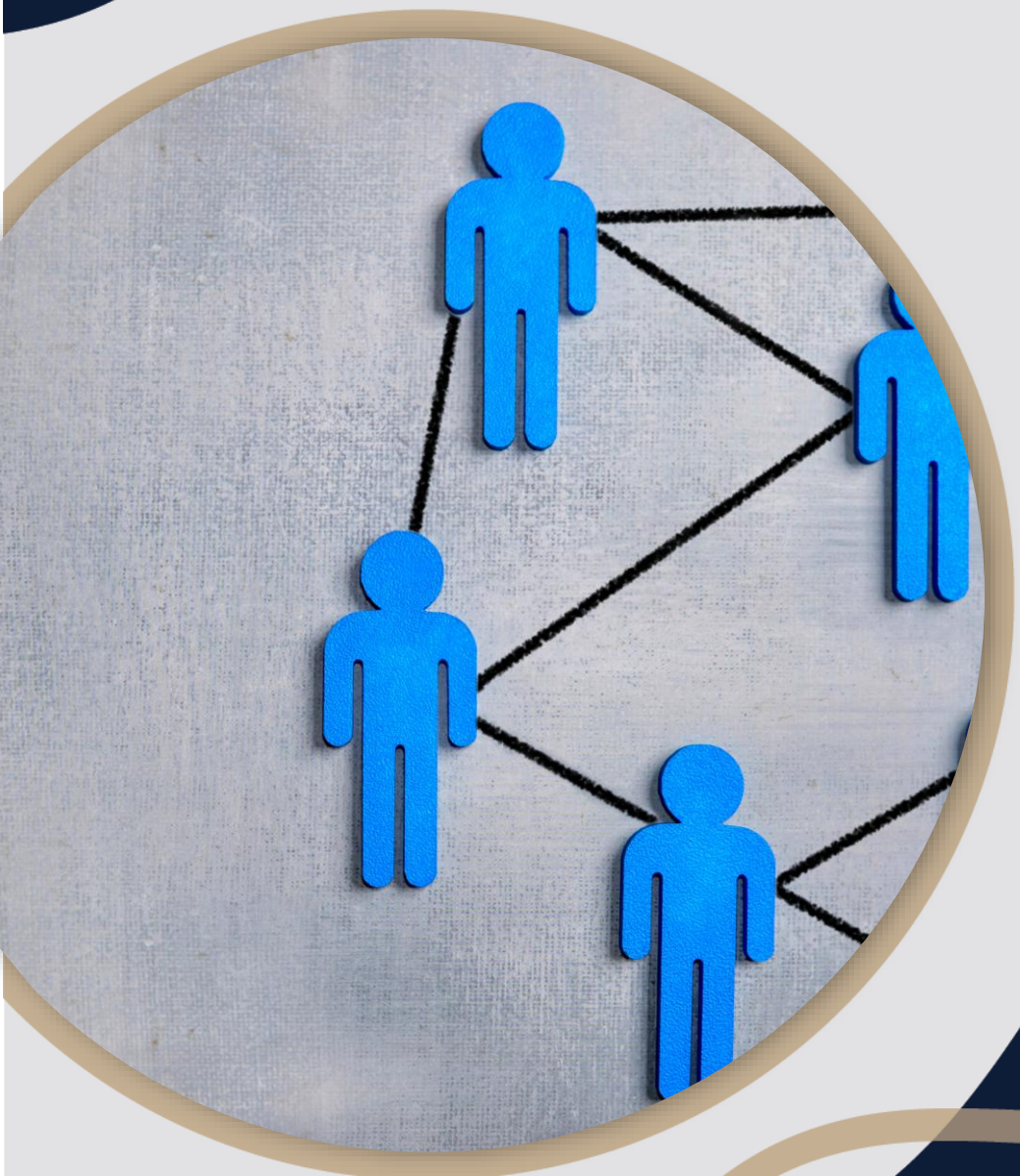

About ANZCA

The Australian and New Zealand College of Anaesthetists (ANZCA), comprising the Faculty of Pain Medicine (FPM) is the professional body responsible for the postgraduate training programs of specialist anaesthetists and specialist pain medicine physicians.

We are one of the largest medical colleges in Australia and New Zealand with 10,000 members.

A key role of the college is fostering the highest standards of clinical practice, safety and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. We do this through our robust training programs, rigorous standards, continuous education, mentoring and supervision of junior doctors, advocacy, and research.

Consultation scope and request

Advice from patients, medical providers and other interested parties on whether current Medicare referral arrangements (pathways between GPs and non-GP specialists as well as between non-GP specialists) are effectively supporting access to specialist care for patients and feedback on the suggestions for reform.

Relevance of referrals

For routine anaesthesia pre-operative consultations, a specific referral is not required. Referrals related to high-risk patient assessments, specialised clinics (such as pain management or allergies), and, in some jurisdictions, specialised obstetric or paediatric services can occur. Referrals (to anaesthetists and pain medicine specialists) are generally initiated by a surgeon, GP, or treating team to optimise patient health before surgery to ensure safety and comfort.

Referrals to specialist pain medicine physicians are typically required for the management of chronic or complex, non-cancer pain, often requiring a multidisciplinary team approach. These specialists are experts in diagnosing and treating pain that has persisted for more than three months, significantly impacts daily function, or has not responded to initial treatments. Referrals are normally provided from a GP or another medical specialist.

Referrals in perioperative medicine are designed to optimise patient health before, during, and after surgery, particularly for high-risk, frail, or medically complex individuals. Perioperative medicine is a multidisciplinary, patient centred approach to higher-risk surgical patient care. These referrals are typically made by GPs, surgeons, or pre-admission clinic staff to specialised teams as soon as surgery is planned to reduce complications and improve outcomes. This team works with the patient and their broader healthcare team, including their GP, to plan strategies to reduce complications, identify risks up front, and implement cost effective and evidence-based interventions to optimise patients and improve fitness prior to surgery. Post surgery, the perioperative care team oversees more efficient patient recovery including prevention or early intervention for postoperative complications.

ANZCA consultation feedback

The college welcomes and supports the Modernising Referral Pathways consultation. Specific feedback from ANZCA is provided below.

Person-centred, innovative models of care

It is important to consider what healthcare may look like even within the next five years and to design systems that anticipate, rather than react to, that change. Care delivery is evolving rapidly, with a greater proportion of care delivered remotely and an increasing integration of wearable devices and digital technologies. Planning should therefore focus on innovative models that support high-quality, technology-enabled care rather than reinforcing structures that may soon become outdated.

Any reforms should be with the lens of access and person-centred design, including dedicated attention to culturally safe approaches, such as for Aboriginal and Torres Strait Islander peoples.

Medical college alignment

It is essential that referral pathways and processes are formally linked to specialist medical college governance. Specialist medical colleges remain the custodians of specialty standards, scope of practice, and training.

Other providers who can issue referrals to non-GP specialists

Page 2 of the consultation paper outlines “Besides GPs, there are a limited number of other providers who can issue referrals to non-GP specialists…such as nurse practitioners.”. Suggest that the “other providers” are listed for completeness, especially considering the list is considered to be limited.

Chronic and complex conditions

As stated in the paper, the current referral system was designed to primarily support management of acute illnesses, rather than chronic and complex conditions which are increasingly becoming more evident. This is the case for pain medicine. Chronic pain patients in specialist services present with substantial clinical, social and psychological complexity.

This typically involves a once-off, longitudinal specialist care particularly for complex pain conditions, or episodic extended consultation to integrate complex biomedical, psychological, and social factors; review high-risk pharmacotherapy; and provide clear, structured recommendations to guide ongoing care in primary care and other specialist settings. These items would not be used to support routine follow-up or ongoing care, but rather to facilitate high-value, time-limited specialist input that improves care coordination, supports GPs, and reduces downstream system costs. Specialist pain medicine physicians also play an important role in supporting primary care by providing diagnostic clarification, risk assessment of pharmacological therapies, and multidisciplinary management plans that enable ongoing care to be delivered safely within community settings. As such, chronic pain is a long-term condition that requires longitudinal specialist involvement and coordinated multidisciplinary care. Referral reform should recognise chronic pain as a standalone condition requiring longitudinal care, aligned with contemporary chronic disease management practices. This aligns with ICD-11 International Classification of Diseases (ICD) of the World Health Organization (WHO) officially recognising chronic pain as a distinct, actionable health condition rather than just a symptom. Referral arrangements should ensure that patients requiring specialist pain medicine assessment are able to access these consultations in a timely manner to support coordinated care and reduce downstream health system costs.

Access to specialist pain medicine services remains limited in many parts of Australia, with significant wait times for multidisciplinary pain clinics and substantial geographic inequity. Referral system reform should therefore support pathways that facilitate timely

access to specialist pain medicine expertise, particularly for patients with complex chronic pain conditions who require multidisciplinary assessment and coordinated care.

This should be considered in the design of referral system and processes that support patient care, including the ongoing financial burden faced by pain patients.

Transparency and awareness

The college would support greater transparency and actions that aim to increase awareness of services for patients. For example, disclaimers and further information in referral letters in plain, clear language and public awareness campaigns on accessing and navigating specialist referrals and services. Depending on the content and positioning, this is something the college would support promoting through members.

Quality of referrals

Worsening quality of referrals is a reality. This defeats the purpose of the mentioned GP as care coordinator model. It also leaves specialists managing patients with limited baseline information, forcing them to repeat assessments, gather missing history, and reconstruct clinical context that should have been provided at the outset.

Length of validity

The college would agree that the three-month non-GP to non-GP referral window should be increased. There should be flexibility to adjust the period depending on the patient's condition, patient preferences (if there is flexibility on when they can undertake the service) and nature of the referrer, rather than having in place a universal or default approach. If the primary rationale for shorter validity periods is to preserve GP oversight, this may need reconsideration. Healthcare delivery and consumer expectations are evolving rapidly, and care is increasingly multidisciplinary and specialist led. In many cases, continuity is no longer exclusively GP-centred. Accordingly, where there is documented, ongoing specialist involvement and active management, longer or conditional indefinite validity periods may be appropriate. For example, an indefinite referral could remain valid provided the patient has continuous follow-up with the specialist, with no break greater than six months (or another agreed time period) between appointments. If that continuity is not maintained (e.g. a patient sees an endocrinologist twice and then does not return for two years), the referral should default back to a defined validity period (e.g. 12 or 24 months) and a new referral should be required to ensure reassessment and updated clinical context. This is particularly relevant for chronic conditions such as persistent pain, where patients may require specialist review over many years. Requiring repeated referral renewal for patients already under active specialist management may create unnecessary administrative burden without improving care coordination.

This principle is relevant to GP to non-GP specialist referral (which is currently 12 months) – in some instances this would be sufficient and in others a longer period is necessary. A 24-month validity period would be reasonable in most cases. However, where a patient is engaged in ongoing, regular specialist care, it is difficult to justify the need for repeated referrals purely for administrative purposes. In such circumstances, an indefinite referral, provided certain conditions are met, could be appropriate. As above, validity could be contingent on continuous follow-up, with reversion to a defined time limit if care lapses.

Risks or challenges with making referrals longer or indefinite by default

At its core, this issue reflects a tension between administrative efficiency and patient convenience on one hand and coordinated primary care oversight on the other. Australia's health system has traditionally been built around GP-led continuity of care.

Making referrals indefinite by default could weaken that structural safeguard unless alternative coordination mechanisms are developed and strengthened. That said, such alternative models may ultimately prove more fit-for-purpose in the future, as patients increasingly prioritise convenience and greater control over their healthcare.

Time-limited referrals currently encourage patients to return to their GP for review, reinforcing the GP's coordinating role. Removing this requirement may reduce those touchpoints. However, as mentioned before, healthcare utilisation patterns are changing. Many patients now seek 24/7 access, often via telehealth and after-hours services, and fewer people, particularly in regions with GP shortages, have an ongoing relationship with a single regular GP. In bulk-billing or high-turnover practices, patients may see a different GP at each visit. For many, the traditional "one GP" continuity model is already diminished or non-existent.

Without clear responsibility for oversight, there is a risk of increased fragmentation of care unless another clinician or system assumes an explicit coordinating function. The greatest clinical risk would likely be among patients with chronic, complex, multi-morbid conditions. However, these patients are also the group most likely to maintain regular GP contact regardless of referral settings.

There is also a possibility of increased specialist utilisation and potential over-servicing. That said, this dynamic arguably already exists, with referrals frequently provided at patient request and defensive medicine becoming more common.

Conversely, reducing appointments that occur solely for referral renewal could free up GP capacity. This may allow longer consultations for complex patients and create greater access for new or unwell patients who need timely primary care.

Barriers of Australia wide digital referral process

Some of the potential barriers of slowing or stopping the take up of an Australia wide digital referral process include:

- **Data privacy and cybersecurity concerns:** patient consent and data-sharing transparency, a centralised platform is an attractive cyber target, medico-legal liability if referral data is compromised or lost. Even perceived risk can slow adoption significantly.
- **Structural friction (public vs private):** public hospitals may mandate while private specialist may opt out.
- **Governance and jurisdictional variation:** competing state-based referral and electronic medical record systems.
- **Consumer concerns about digital tracking of health information:** some patients may be uncomfortable with increased digital capture and tracking of their health information, particularly if they are unclear about who can access their data and for what purposes.
- **Geographic and socioeconomic digital divide:** significant rural and remote variation in connectivity may increase equity gaps.
- **Inadequate interoperability:** primary care, specialist, and hospital sectors use a wide range of clinical software systems. Poor interoperability between these platforms, high integration costs, and the risk of introducing yet another system that does not seamlessly integrate into existing workflows could be major barriers to uptake.

Multiple choice responses - General consultation questions

The college's responses to the identified questions are provided below, on a scale of 1-5, where 1 means disagree completely and 5 means strongly agree.

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

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