RACGP
Royal Australian College of General Practitioners

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14 August 2026

Specialist Affordability Section
Medical Benefits and Digital Health Division
MBS Policy and Specialist Programs Branch
Department of Health, Disability and Ageing
GPO Box 9848, Canberra ACT 2601

Via email: specialistaffordability@health.gov.au

Dear Specialist Affordability team

RE: Public consultation on Fee Transparency in Health Care

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to respond to the Department of Health, Disability and Ageing's (DoHDA) consultation on *Fee Transparency in Health Care*, which seeks feedback on reforms to informed financial consent and disclosure arrangements, including the role of legislation, regulation, compliance, and education.

As the peak representative body for more than 50,000 specialist general practitioners (GPs) working in metropolitan, regional, rural and remote communities across Australia, the RACGP is committed to supporting GPs to meet the healthcare needs of the Australian population.

The RACGP supports informed financial consent and fee transparency and recognises the importance of ensuring patients have access to clear, timely, and understandable information about the costs of their healthcare. However, Options 1 to 5 of the proposed reforms risk increasing administrative burden on general practice, creating more "Red Tape" and diverting time and resources away from patient care, increasing workforce pressures, and undermining general practice viability. General practices should not be expected to assume responsibility for communicating costs associated with services delivered by other providers, nor should it be burdened by compliance requirements that are not consistently applied across the wider healthcare system.

On balance, the RACGP supports Option 6, with amendment. Education, guidance and voluntary compliance measures are likely to be more effective at addressing inappropriate billing practices, whether inadvertent or otherwise, than additional regulatory or enforcement mechanisms. Improving awareness and understanding of existing requirements will better support informed financial consent, improve transparency for patients and reduce the risk of non-compliant billing practices, while avoiding unnecessary administrative burden on general practice.

If you have any questions or concerns regarding this submission, please contact Samantha Smorgon, Head of Funding and Health System Reform, on (03) 8699 0566 or via healthreform@racgp.org.au.

Your sincerely

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RACGP response to Fee Transparency in Health Care Consultation

Informed Financial Consent and Split Billing Practices

July 2026

RACGP

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1. Executive Summary

The Royal Australian College of General Practitioners (RACGP) supports informed financial consent and fee transparency and recognises the importance of ensuring patients have access to clear, timely and understandable information about the costs of their healthcare. The RACGP supports a modified implementation of Option 6 and does not support the remaining options in their current form. Options 1-5 (inclusive) rely primarily on expanded regulatory, compliance or enforcement mechanisms that risk increasing administrative Red Tape without addressing the underlying challenges associated with informed financial consent. The proposed requirements do not adequately address the practical challenges associated with legal enforcement, including the cost, complexity and administrative burden of pursuing fee disputes.

Informed financial consent can be challenging within a healthcare system characterised by fragmented care pathways, multiple providers and complex funding arrangements. While specialist general practitioners (GPs) help patients navigate the health system, they are unable to provide definitive information about fees charged by other services and/or providers. Further, general practice involves longitudinal care, evolving clinical presentations and care needs that cannot always be determined in the consultation. As a result, reforms must be practical, proportionate and reflective of the information reasonably available to practices and practitioners.

These proposals risk diverting time and resources away from patient care, increasing workforce pressures and adversely affecting practice viability. Reforms should recognise that lawful mixed billing and split billing arrangements are established components of the Medicare framework that support patient access and practice sustainability. Future reforms should strengthen existing approaches rather than create additional regulatory burdens.

The RACGP supports strengthening informed financial consent through education, guidance and better use of existing professional, accreditation and regulatory frameworks, including the RACGP Standards for General Practices, the RACGP General Practice Patient Charter and the RACGP informed financial consent resource. Wherever possible, reforms should build on these established arrangements rather than introduce duplicative regulatory requirements.

2. RACGP's recommendations

The RACGP recommends the government:

- prioritise education, guidance and voluntary compliance measures before introducing additional regulatory, compliance or enforcement requirements, including promoting existing informed financial consent resources and improving awareness of Medicare billing obligations
- build on existing professional, accreditation, Medicare and regulatory frameworks rather than creating duplicative red tape requirements or new regulatory structures
- design reforms in partnership with the profession to ensure they are practical, proportionate and reflective of the realities of general practice, including continuity of care, evolving clinical presentations, variable consultation complexity and mixed billing models
- apply fee transparency requirements consistently across the healthcare system and avoid imposing obligations on general practice that exceed those applied to other providers or require disclosure of information that is not reasonably available to practitioners at the point of care
- protect patient access to care and practice sustainability by preserving flexibility for lawful mixed and split billing arrangements and avoiding reforms that discourage bulk billing or create unnecessary administrative red tape
- improve provider and patient understanding of Medicare billing requirements, including bulk billing obligations and inappropriate charging practices, through targeted education, clearer guidance and system support
- support technology-enabled solutions that improve fee transparency, patient understanding and informed financial consent while minimising additional administrative burden for practices
- monitor and evaluate the impacts of any reforms on patients, practitioners, practice owners, practice viability, administrative burden and access to care across different medical specialities and engaged with the RACGP before expanding compliance activities.

3. Summary of RACGP position on proposed reform options

The RACGP provides the below reform positions:

Reform option	RACGP position	Rationale	Amendment
Option 1 – PSR function expansion	**Do not support**	Expansion of the PSR's role risks increasing perceived compliance pressures on GPs and practice staff. May increase administrative burden and contribute to higher patient out-of-pocket costs without recognising the complexity of billing arrangements and informed financial consent in general practice.	N/A
Option 2 – DoHDA compliance role expansion	**Do not support**	General practice is structurally different from non-GP specialist private practice and operates within a distinct funding, workforce and service delivery context. Expanding compliance responsibilities may impose additional administrative burden and red tape on practices, diverting resources from patient care and placing further pressure on practice viability.	N/A
Option 3 – Health Practitioner Regulation National Law	**Do not support**	Existing Medicare legislation, professional obligations and compliance mechanisms already provide a framework for addressing inappropriate billing practices. Additional regulation risks duplication and may create confusion regarding lawful billing practices.	Clarify the definition of split billing and distinguish between problematic practices and lawful mixed and split billing arrangements within the Medicare framework.
Option 4 – Establish new regulator	**Do not support**	Existing professional, regulatory and accreditation frameworks already establish expectations regarding ethical conduct, professionalism and patient-centred care. Creating a new regulator would be costly, duplicate existing oversight arrangements and introduce unnecessary complexity and regulatory burden without clear benefit to patients.	N/A
Option 5 – Expand powers of ACCC	**Do not support**	A consumer protection approach[1] alone may oversimplify the complexity of general practice and the context in which healthcare services are delivered. Existing regulatory, professional and accreditation mechanisms are better placed to support informed financial consent while balancing patient access, continuity of care and practice sustainability.	N/A
Option 6 – Education, guidance and voluntary compliance	**Support with amendment**	Patients should have access to meaningful information about healthcare costs. However, out-of-pocket costs are influenced by factors including patient complexity, local workforce availability,	Ensure any cost information is contextualised and accurately reflects the factors influencing

		service accessibility, socioeconomic factors and practice operating costs[1].	fees in general practice. Avoid simplistic comparisons that may misrepresent value, complexity or quality of care.

4. Background

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to provide feedback on the Department of Health, Disability and Ageing's (DoHDA) consultation paper, Fee Transparency in Health Care: Informed Financial Consent and Split Billing Practices.

The RACGP is the voice of specialist general practitioners (GPs), representing more than 50,000 members working in metropolitan, regional, rural and remote communities across Australia. As the national peak body for general practice, our core commitment is to support GPs to address the primary healthcare needs of the Australian population.

Reform must recognise the unique role of general practice and the broader healthcare system in which care is delivered. General practice is the most cost-effective part of Australia's healthcare system, yet many practices operate in an environment where Medicare rebates do not reflect the true cost of delivering comprehensive, relationship-based care. Consequently, mixed billing arrangements remain necessary to support practice viability and patient access to care.

Government initiatives have increasingly sought to encourage higher rates of bulk billing to improve affordability. While the RACGP supports affordable access to care, GPs are not required to bulk bill Medicare services, and many practices must continue to rely on lawful mixed and private billing arrangements to remain financially sustainable. Fee transparency reforms should support informed patient choice without unintentionally discouraging lawful billing models or undermining practice viability.

5. Response to the Department's Consultation on Fee Transparency in Healthcare

5.1 Do you think IFC should be legally enforceable in Australia?

The RACGP supports informed financial consent as a fundamental patient right. While patients should be informed of likely out-of-pocket costs, there is a risk that broad legislative requirements could inappropriately capture matters better addressed through professional standards. Although the paper highlighted informed financial consent is an important element of professional conduct, ethical practice and accountability, it does not adequately address the **practical challenges associated with legal enforcement**, including the financial and procedural thresholds that would constitute a breach.

5.1.1 Existing regulatory and compliance frameworks

General practice already operates within a substantial regulatory environment encompassing accreditation, privacy, professional, governance and Medicare compliance requirements. Specialist GPs and other medical practitioners are already subject to ethical and professional obligations under established codes of conduct, and issues of professionalism should not automatically be escalated into matters of legal enforcement. Thus, the **RACGP does not support Option 4**.

The RACGP does not support introducing additional informed financial consent-specific regulatory requirements without addressing the broader regulatory landscape as this may contribute to additional unnecessary regulatory burden and red tape that takes away the ability to focus on patient care. Before introducing new requirements, government should assess whether existing mechanisms – including professional standards, consumer protection arrangements, accreditation frameworks and complaint pathways – can be strengthened or better coordinated to achieve fee transparency objectives.

Transparent billing practices support informed decision-making, strengthen trust between patients and healthcare providers, reduces billing disputes and complaints, and help practices sustainably recover the costs of delivering safe, high-quality care. Considering this, the RACGP has consistently supported compliance reforms that improve transparency and integrity through existing mechanisms including:

- Australian Commission on Safety and Quality in Health Care (ACSQHC) requirements[2] relating to informed financial consent in both the National Safety and Quality Health Service Standards and for general practices under their National General Practice Accreditation Scheme
- guidance[3] provided by the Commonwealth Ombudsman for private patients receiving hospital care
- complaint resolution pathways[4] available through the Commonwealth Ombudsman and the Private Health Insurance Ombudsman
- professional obligations under existing medical standards of conduct.

Accordingly, the **RACGP does not support Option 3** unless the definition of split billing is clarified to distinguish inappropriate conduct from lawful Medicare billing arrangements.

5.2 Do you think medical providers should be penalised for not providing IFC to their patients?

General practice is structurally different from non-GP specialist private practice, and operates within a distinct funding, workforce and service delivery context. General practices should not be penalised for the context in which they deliver care. Thus, any future reforms should build on existing frameworks and recognise the unique nature of general practice, including its longitudinal relationship with patients, diverse practice models and significant contribution to accessible, high-quality care. Therefore, the **RACGP does not support Option 2**.

5.3 Which regulatory approach do you consider most effective for strengthening IFC?

5.3.1 Protecting informed financial consent without increasing red tape

Many general practices already discuss fees with patients before services are provided. The RACGP's primary concern is therefore not the principle of informed financial consent itself, but the risk that future reforms may increase administrative burden and red tape without improving patient outcomes.

While the RACGP supports informed financial consent and fee transparency, a consumer protection-focused approach[1] risks reducing healthcare to a transactional exchange and may not adequately account for the complexity of care provided in and by general practice. General practices deliver safe, coordinated, comprehensive, person-centred care that extends beyond individual episodes of treatment and is particularly important in preventive healthcare, chronic disease management, Aboriginal and Torres Strait Islander healthcare delivery, and care for vulnerable communities. The value of continuity, trust, and long-term doctor-patient relationships cannot be underestimated and must be recognised alongside transparency objectives; hence, the **RACGP supports Option 6 with amendment**.

The RACGP acknowledges moiety (the practice of bulk billing while charging additional fees - for example, consumable fees, administration fees, membership fees or registration fees) remains an ongoing compliance concern and forms part of government's enduring compliance priorities. The RACGP welcomes the opportunity to work with government to improve provider and patient understanding of bulk billing requirements. This reinforces the value of Option 6, as education, **guidance and voluntary compliance measures are likely to be more effective** at addressing inappropriate billing practices, whether inadvertent or otherwise, than additional regulatory or enforcement mechanisms.

Improved understanding of existing requirements will strengthen informed financial consent, support transparency and reduce the risk of non-compliant billing practices.

5.4 Should IFC require disclosure of the total expected cost of an episode of care, including costs billed separately by other providers?

As recognised in the consultation paper, informed financial consent can be challenging within a healthcare system characterised by fragmented care pathways, multiple providers and complex funding arrangements. While GPs play an important role in helping patients navigate the health system, they are often unable to provide accurate information about fees charged by other providers (e.g. non-GP specialists, allied health providers).

Unlike many non-GP specialist settings, general practice involves evolving clinical presentations and consultation lengths that cannot always be accurately determined at the time of booking or predict the care that is required. As a result, it is

not always possible to provide precise cost information in advance. **General practice should not be responsible for providing information about fees charged by other practitioners or organisations, nor should it be subject to compliance obligations that are not applied consistently across the broader healthcare system.**

5.5 Who should IFC obligations apply to?

General practice already incorporates informed financial consent into routine patient care through discussions about consultation fees, out-of-pocket costs and ongoing management, recognising that these conversations are integral to shared decision-making and continuity of care. The current RACGP *Standards for general practices* (5th edition) has requirements for accredited general practices to communicate billing principles, and to inform patients about the cost of care initiated by the practice, including potential out-of-pocket costs for referred services. RACGP considers these measures sufficient to ensure informed financial consent. Further regulation and compliance requirements would provide limited additional value for patients and would only add to the already existing regulatory red tape and compliance burden for general practice. Therefore, any new obligations should not apply to general practices or general practitioners.

5.6 Which information should IFC reasonably require providers to disclose?

5.6.1 Information requirements for IFC should align with existing professional and accreditation standards

The soon to be released RACGP *Standards for general practices* (6th edition) further strengthens the existing accreditation framework in relation to fee transparency, informed financial consent and Medicare billing education.

Standard PP1 – Information about the practice, requires practices to provide patients with clear information about fees, billing arrangements and likely out-of-pocket costs, supporting transparency and enabling patients to make informed decisions about their care. Standard CG3 further reinforces this by promoting shared decision-making and ensuring patients are supported to understand information relevant to their care, including factors that may influence treatment decisions. The Standards also promote **patient-centred communication and health literacy**, creating an environment in which discussions about healthcare costs can occur as part of routine care planning.

In addition, Standard F4.B requires practices to make team members aware of Medicare billing education resources and support ongoing billing awareness and compliance, **reinforcing a preventative and educational approach to improving billing practices**. These requirements form part of the national general practice accreditation framework and are externally assessed through accreditation processes, providing an established mechanism to support implementation and continuous quality improvement.

Therefore, these requirements demonstrate that the existing accreditation framework already supports the objectives of improved fee transparency and informed financial consent. Any **future reforms should build on these well-established requirements and avoid creating unnecessary duplication or additional regulatory burden for general practice**. Rather than introducing new requirements, priority should be given to education, guidance and support that strengthen implementation of existing professional and accreditation standards.

5.7 Should IFC be provided in writing?

No. Informed financial consent should be provided in the form in which it is most appropriate and effective for the patient to receive and understand that information. Mandating the provision of IFC in writing does not mean it will always be appropriately explained or understood.

The RACGP supports reforms that improve fee transparency, protect consumer interests, and reduce uncertainty for both patients and providers. In line with that, we have developed an informed financial consent resource to better support general practice teams to have clear and transparent conversations with their patients about healthcare costs and help patients make informed decisions, appropriate to the patient's needs in that community.

Existing expectations regarding fee transparency and informed financial consent are reflected in the RACGP Standards for general practices (5th edition)[5], specifically at mandatory Criteria C1.1A C1.5A, and C1.5B, which promote **proactive communication** regarding the costs of care and support informed patient decision-making.

5.8 Do you think existing professional codes of conduct provide sufficient clarity on IFC?

5.8.1 Support for informed financial consent and fee transparency

Yes. The existing professional frameworks underpinning general practice provide sufficient clarity on informed financial consent, specifically the RACGP's Clinical competency rubric, the RACGP General Practice Charter and the overarching Medical Board of Australia's *Good medical practice code*. Alongside the RACGP's Standards for general practices, these frameworks embed informed financial consent through professionalism as a core competency requirement to become a specialist GP. Collectively, these positions promote clear communication about fees and expected out-of-pocket costs, while supporting patients to seek clarification where required. The Good Medical Practice code further emphasises the obligation of GPs to act ethically, honestly and transparently. As such, general practice already plays an important part in supporting transparency through established professional standards, accreditation requirements, and patient-centred practices.

5.9 Are there key risks or unintended consequences that IFCs reforms should seek to avoid?

5.9.1 General practice viability and billing arrangements

General practice is the most cost-effective part of the Australian healthcare system and provides most of the patient care[6] within the community. However, Medicare funding often does not reflect the true cost of delivering comprehensive, safe, coordinated, high-quality, and increasingly complex, care. While recent government investment[7] in bulk billing incentives has supported many practices, particularly in rural and remote areas, concerns remain that these incentives do not fully offset the costs of delivering comprehensive care.

Longer consultations[7] are increasingly required to manage chronic and complex conditions, however a patient's rebate decreases the longer they spend with their GP in one consultation. The RACGP has consistently called for an increase to the patient rebate for long consultations, to better reflect the changing healthcare needs in the Australian community and the costs of more delivering complex care. These funding calls remained unanswered as a result many practices have no option but to charge private fees to remain financially viable.

Fee transparency reforms must be considered within the context of general practice viability and the rising costs of care[8]. Rising practice costs, workforce pressures and inadequate annual MBS indexation[7] (not aligned to the Consumer Price Index) have contributed to greater reliance on mixed and private billing models. This further reinforces the importance of clear communication regarding fees, rebates and expected out-of-pocket costs.

It is important to recognise that split billing is an established and lawful feature of the Medicare system. In the Medicare context, split billing generally occurs where multiple services are provided on a single occasion with some services are bulk billed, while others are privately billed. Any reforms relating to fee transparency or informed financial consent should avoid creating confusion about existing billing practices or imposing restrictions beyond current Medicare requirements.

5.9.2 Patient access, affordability and education

Fee transparency reforms must not intentionally create barriers to care.

Affordability remains a significant barrier for many patients[9], particularly in relation to non-GP specialist services and diagnostic investigations. Rising out-of-pocket costs can affect patients' willingness to proceed with recommended investigations and treatment, potentially jeopardising their healthcare. However, the trusted relationship between patients and their GP plays an important role in supporting informed decision-making about healthcare costs and treatment options.

The RACGP supports practical approaches that improve patient understanding of healthcare costs while preserving access to care. Education, guidance and voluntary compliance measures are more likely to strengthen informed financial consent than additional regulatory[10] requirements. The RACGP provides education, resources and professional development activities to support safe, transparent and compliant billing practices, including for practitioners new to the Australian healthcare system.

5.10 What role could digital tools play in supporting IFC?

The RACGP supports the use of digital solutions to improve fee transparency and patient awareness of healthcare costs. This could include enhancements to existing Medicare systems that provide patients with real-time information about their progress towards Medicare Safety Net (MSN) thresholds, MyMedicare registration details, Health Assessment and

care team member information. Such measures would strengthen informed financial consent, improve cost transparency and support more informed discussions about the cost and management of care between patients and their healthcare providers.

5.11 Should providers be required to issue a single bill for all items/services associated with an episode of care?

5.11.1 Definition of split billing requires clarification

The consultation paper acknowledges that split-billing practices may, in some circumstances, reflect the gap between government funding and the actual costs of delivering care. However, the paper's definition of 'split billing' risks conflating lawful billing practices in general practice with behaviours intended to circumvent Medicare requirements. Where multiple services are provided to a patient during a single attendance, it is permissible for some services to be bulk billed and others to be privately billed, except where restricted by Medicare requirements, such as the multiple services rule.

While the RACGP does not support inappropriate billing practices or attempts to circumvent Medicare requirements, it notes that the consultation paper uses 'split billing' as a broad term encompassing a range of behaviours. The RACGP welcomes further research into the underlying drivers of these practices, including the adequacy of Medicare rebates, the design of bulk-billing incentives, and the impact of rising operating costs on the sustainability of general practice business models.

The RACGP's 2026-2027 pre-budget submission called for the establishment of an Independent Primary Care Pricing Authority, which would determine the true cost of delivering care across diverse populations.

5.12 Are there any key issues or consideration missing from this paper?

5.12.1 Factors influencing patient out-of-pocket costs should be recognised and contextualised

Patient out-of-pocket costs are influenced by a range of factors, including:

- patient demographics and healthcare needs
- socioeconomic circumstances
- geographic location of both the patient and the practice
- local service access and workforce availability
- government incentives and funding arrangements.

These factors affect practice billing models. The RACGP does not support applying tools such as the Medical Cost Finder to general practice. Without appropriate contextualisation of patient complexity, multidisciplinary care arrangements and local operating costs the information provided in such a tool could be misleading and cause patients to not seek care. **Therefore, this position supports Option 6 with amendment.**

5.12.2 Reforms must be proportionate, practical and avoid unnecessary regulatory burden

The RACGP supports reform that improves transparency and patient understanding of healthcare costs. However, reforms should complement existing professional obligations, accreditation requirements and consumer protections. There needs to be a clear distinction between practices that are already compliant with Medicare requirements and any proposed new transparency obligations.

The consultation paper appropriately identifies challenges arising from fragmented regulatory arrangements and inconsistent approaches to informed financial consent. However, poorly designed or under-resourced regulatory interventions risk creating additional administrative burden without improving patient outcomes which the College considers will be the case for Options 3, 4 and 5.

Consistent with previous RACGP submissions regarding Medical Cost Finder reforms[11], Medicare compliance measures, referral pathways[12] and technology-enabled compliance activities[13], any reforms should balance transparency objectives with patient access, practice viability and minimisation of unnecessary administrative burden.

6. References

[1] Attinger SA, Kerridge I, Stewart C, Karpin I, Gallagher S, Norman RJ, Lipworth W. Money matters: a critique of informed financial consent. *Med Law Rev*. 2024;32(3):356-372. doi:10.1093/medlaw/fwae015

[2] Australian Commission on Safety and Quality in Health Care. Advisory AS18/10: Informed financial consent. ACSQHA. November, 2021. Accessed July 13, 2026. https://www.safetyandquality.gov.au/accreditation/advisories/advisory-as1810-informed-financial-consent

[3] Commonwealth Ombudsman. Informed financial consent: Are you going to hospital as a private patient? The Commonwealth Ombudsman. Accessed July 13, 2026. https://www.ombudsman.gov.au/publications-and-news-pages/publication-pages/brochures-and-factsheets/factsheets/private-health-insurance/informed-financial-consent

[4] Commonwealth Ombudsman. Private health insurance complaints: What we can do. The Commonwealth Ombudsman. Accessed July 13, 2026. https://www.ombudsman.gov.au/complaints/private-health-insurance-complaints

[5] Royal Australian College of General Practitioners. Core module: Criterion C1.5 – Costs associated with care initiated by the practice. RACGP. February 24, 2023. https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed/core-standards/core-standard-1/criterion-c1-5-costs-associated-with-care-initiate

[6] Royal Australian College of General Practitioners. General practice health of the nation report 2024. Accessed July 13, 2026. https://www.racgp.org.au/health-of-the-nation/chapter-3-general-practice-viability/government-contribution-to-care

[7] NewsGP. 'Inadequate' MBS indexation revealed. May 29, 2026. https://www1.racgp.org.au/newsgp/professional/inadequate-mbs-indexation-revealed

[8] Royal Australian College of General Practitioners. General practice health of the nation report 2025. Accessed July 13, 2026. https://www.racgp.org.au/health-of-the-nation-2025/about-the-report

[9] Venning B, Bergin R, Pearce A, Lee A, Emery J. Factors affecting patient decisions to undergo testing for cancer symptoms: An exploratory qualitative study in Australian general practice. BJGP Open. 2022;7(1):0168. doi.org/10.3399/BJGPO.2022.0168

[10] Philip P. Independent Review of Medicare Integrity and Compliance: Final Report. Canberra: Department of Health and Aged Care; 2023. Accessed July 13, 2026. https://www.health.gov.au/sites/default/files/2023-04/independent-review-of-medicare-integrity-and-compliance-final-report.pdf

[11] Royal Australian College of General Practitioners. RACGP response to Senate Community Affairs Legislation Committee inquiry. March 31, 2026. Accessed July 20, 2026. https://www.racgp.org.au/advocacy/reports-and-submissions/view-all-reports-and-submissions/2026-reports-and-submissions/health-legislation-amendment

[12] Royal Australian College of General Practitioners. RACGP to DoHDA re modernising referral pathways. March 12, 2026. Accessed July 13, 2026. https://www.racgp.org.au/getmedia/7b14b47e-1a72-41d4-9a98-efef8cd0fcad/RACGP-to-DoHDA-re-Modernising-referral-pathways-Letter-Signed-12-March-2026.pdf.aspx

[13] Royal Australian College of General Practitioners. RACGP submission to ANAO AI audit Final 22 April 2026. April 22, 2026. Accessed July 13, 2026. https://www.racgp.org.au/getmedia/993397c4-a92b-46e6-823c-667991b335ed/RACGP-Submission-to-ANAO-AI-audit-Final-22-April-2026.pdf.aspx