Australian Society of **Anaesthetists**®

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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Via email: community.affairs.sen@aph.gov.au

Community Affairs Legislation Committee Inquiry into the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026*

Dear Committee Secretary,

The Australian Society of Anaesthetists (ASA) welcomes this opportunity to make a submission to the Community Affairs Legislation Committee inquiry into the Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026.

About the Australian Society of Anaesthetists

The ASA was formed in 1934 and is a member-funded organisation dedicated to supporting, representing and educating specialist anaesthetists to ensure the safest possible anaesthesia for the community. We have proudly supported specialist anaesthetists for over 90 years and continue to support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public.

Specialist anaesthetists engage with patients at critical moments of care and provide anaesthesia services across a wide range of settings. Australian anaesthetists deliver care to recognised clinical and safety standards within the Australian healthcare system. In the private sector alone, Australian anaesthetists provide more than 7,000 episodes of care each day, generating valuable insights into the patient journey.

Key Recommendations

The ASA supports measures in the Bill to enhance transparency in healthcare pricing, enable consumers to make better informed decisions about their care and to derive better value from their private health insurance. However, these must be paired with measure that address inadequate indexation of MBS and private health insurer benefits and gap cover arrangements.

Therefore, the ASA recommends the following actions to the Community Affairs Legislation Committee:

1. It is absolutely essential that the **Transparency by Default** measure in the Bill is accompanied by fit-for-purpose data definitions and consumer context, to ensure information published on the Medical Costs Finder strengthens, rather than weakens, patient informed financial consent.
2. Ensure a fast, simple and low-cost correction pathway for doctors to promptly amend any inaccurate published data about them or their fees.
3. MBS and private health insurance anaesthesia rebates should be regularly indexed to better reflect the real cost of providing specialist care.
4. Private health insurers should regularly index known-gap limits and review gap-cover settings, so these keep pace with the real costs of providing specialist care.
5. Support the timely completion and implementation of the current MBS Anaesthesia RVG review, as the most appropriate and proportionate mechanism to modernise anaesthesia items, reduce compliance risk, and safeguard the integrity of the MBS.

Introduction

The ASA supports reforms that strengthen transparency and consumer protection, including clearer information for patients about specialist fees and more robust oversight of private health insurance premiums.

We note the Explanatory Memorandum which accompanied this Bill states that to support the proposed publication of information on the Medical Costs Finder, the department will develop an analytical approach for the derivation of a single fee figure that can be published for a medical practitioner’s provision of a service for a given financial year.

Additionally, the department will publish information about the analytical approach and establish a process for medical practitioners, hospitals and insurers to enquire or request the department to review the information published about them. An internal review process, rather than merits review, is considered appropriate, given broader public benefit of costs transparency for consumers and communities and given the amendments propose to publish defined, limited, non-sensitive information about medical practitioners, hospitals and insurers, with much of the information being already publicly available. Judicial review will still be available to medical practitioners, hospitals and insurers.

Fee transparency alone however will not address the underlying drivers of affordability and access. Long-term, inadequate indexation of Medicare Benefits Schedule (MBS) rebates and private health insurance benefits is eroding the sustainability of specialist anaesthesia services, particularly after-hours and in regional settings.

Sustainable access also requires funding reform. Without cost-reflective, predictable indexation settings, workforce constraints, which we identified in our Anaesthetist Workforce Modelling Final Report published in August 2024 will translate into worsening access for patients in the private hospital system.

About the Bill

The Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026 (the Bill) will introduce two key measures:

1. **Transparency by Default:** amend the Health Insurance Act 1973 (HI Act) and Private Health Insurance Act 2007 (PHI Act) to allow the Department of Health, Disability and Ageing (the department) to publish information for consumers on medical fees charged by medical practitioners (including specialists and general practitioners) and likely out-of-pocket costs for their private healthcare experience. The purpose is to support greater transparency in healthcare pricing, helping consumers make informed decisions about their healthcare and obtain better value from private health insurance.
2. **Regulating premiums:** amend the PHI Act to require insurers to seek Ministerial premium approval for new products, and existing products where certain changes are proposed. The new premium approval process provided in the Bill broadly aligns with the current process for premium changes for existing products. The purpose of these provisions is to expand and formalise Ministerial oversight of premium setting for private health insurance products.

2026 ASA Specialist Fees and Patient Out-of-Pocket Costs Survey

In early 2026 the ASA undertook a Specialist Fees and Patient Out-of-Pocket Costs survey to examine:

- current anaesthesia fee practices
- participation in private health insurer arrangements
- approaches to informed financial consent, and
- patient-related considerations associated with out-of-pocket costs.

This research was designed to provide an overview of how these issues are currently experienced and managed by specialist anaesthetists in private practice settings across Australia.

The findings are based on a national, quantitative online survey conducted in January and February 2026. The survey was developed and conducted by Survey Matters in consultation with the Australian Society of Anaesthetists.

A total of 1,121 responses were received from specialist anaesthetists – approximately 24 per cent of anaesthetists working in private or mixed public-private practice – with results reported in aggregate to describe patterns and practices across different state and territory jurisdictions.

> ***A copy of the ASA Specialist Fees and Patient Out-of-Pocket Costs Survey will be provided to the Community Affairs Legislation Committee for the purpose of this inquiry. We request that the document be treated as confidential until the document is published by the ASA in mid-to-late April 2026.***

Key findings

a) Anaesthesia fees are influenced by clinical and pricing factors, including procedure duration and complexity and private health insurance gap arrangements. Minimising out-of-pocket costs and patient demographics and ability to pay also feature prominently in factors influencing anaesthesia fees.

b) The majority of anaesthetists participate in private health insurer gap arrangements, which is consistent with data published by the Australian Prudential Regulation Authority (APRA).

c) Most anaesthetists provide clear fee estimates and likely out-of-pocket costs as part of informed financial consent, with the majority including core information such as estimated fees or ranges, expected out-of-pocket expenses, and potential fee variations if clinical circumstances change.

d) Patient complaints regarding out-of-pocket costs are relatively uncommon.

e) Patients report that greater clarity is needed around the fact that professional fees are set independently of insurance rebates, which function as subsidies and have not kept pace with the costs of delivering specialist care.

f) Most anaesthetists believe that patients would benefit from a clearer understanding that professional fees are set independently of Medicare and private health insurance rebates, which are merely subsidies that have failed to keep pace with the actual costs of providing specialist care.

Informed Financial Consent

The ASA's Position Statement on Informed Financial Consent (ASA-PS04) outlines the importance of informed financial consent (IFC) and reflects a consensus position that AMA fees represent generally accepted maximums, except where extenuating circumstances apply.

Informed Financial Consent is any communication (verbal or written) undertaken between a medical practitioner or his/her representative and a patient such that the patient understands the potential fee for the medical procedure, and the potential rebates for the services from Medicare and/or the patient's private health insurer.

The ASA considers the gold standard for IFC to be a written estimate of the anaesthesia fee (a range is acceptable) together with a reasonable indication of likely out-of-pocket expenses, provided to the patient prior to the day of the procedure along with written acceptance by the patient. The ASA acknowledges that this standard will not always be achievable. However, the ASA strongly advises members to adopt best possible IFC practices, with the aim of achieving this gold standard wherever possible.

Obtaining IFC is more difficult for anaesthetists than for most other specialists, particularly for day surgery patients, day-of-surgery admission (DOSA) patients and emergency patients.

AMA fees refer to the fees listed in the Australian Medical Association (AMA) List of Medical Services and Fees, commonly called the AMA Fees List. AMA fees are not mandatory and provide guidance only. They are professionally developed reference fees published annually by the AMA to help doctors determine fair and reasonable charges for medical services.

Our survey on Specialist Fees and Patient Out-of-Pocket Costs found that for planned procedures, informed financial consent is typically provided in advance, most often in writing and managed through anaesthetic practices or billing systems. Fee estimates and likely out-of-pocket costs are routinely included, indicating that structured consent processes are embedded in anaesthetist processes for planned care.

In unplanned and emergency admissions, informed financial consent is obtained verbally at the time of care. Many anaesthetists report defaulting to no or known gap billing in these situations mostly due to time pressure and patient circumstances. Respondents also frequently report awkwardness in discussing fees with patients in times of distress, and ethical concerns about obtaining consent, leading to waiving and reducing fees.

Finally, our survey also found that requests from patients to reduce fees are common, and that most anaesthetists report reducing or waiving fees in a small proportion of cases. Decisions are most often influenced by patient financial hardship, professional discretion and clinical context, indicating that flexibility in charging is a regular part of anaesthesia practice.

What is driving increasing health care costs?

The conversation about specialist medical fees, including fees for anaesthetists, is increasingly loud, but not always accurate.

Private health insurers pay significantly more for hospital accommodation, theatre fees, nursing, etc than they do for medical specialist fees. Anaesthetists' fees in particular make up only a small share of total benefits.

Annual private health insurance membership and benefits statistics published by the Australian Prudential Regulation Authority (APRA) in December 2025[1] indicate that, in 2024–25, private health insurers paid the following amounts in patient rebates:

Table 1: Private health insurer benefits paid by category (2024–25, \$ billions)

Year	Hospital benefits (\$b)	Medical benefits (\$b)	Devices / prostheses etc (\$b)	Total hospital treatment benefits (\$b)
2024–25	13.821	2.825	2.423	19.069

Hospital Benefits ($13.8 billion) are payments to private hospitals for accommodation, theatre, nursing, ICU, and related hospital services (**excluding medical practitioner fees**) and represent the largest proportion (72.5 per cent) of total hospital treatment benefits.

Medical Benefits ($2.8 billion) are payments for in-hospital medical services (i.e. specialist fees paid by insurers, excluding Medicare) represent 14.8 per cent of total hospital treatment benefits.

Medical devices / prostheses etc ($2.4 billion) are payments for prostheses, implants, and human tissue products supplied during hospital episodes and represent 12.7 per cent of total hospital treatment benefits paid by health insurers.

In 2024-25 private health insurers paid $19.069 billion in "total hospital treatment" benefits.

The growing gap between cost of providing anaesthesia and MBS and PHI anaesthesia rebates

A defining moment in the history of the ASA was its adoption of the Relative Value Guide (RVG) in 1970 and the subsequent adoption of the RVG by the AMA into its List of Medical Services and Fees in 1989. The Relative Value Guide for Anaesthesia was finally adopted into the Medicare Benefits Schedule in November 2001 (Category 3, Group T.10, Subgroups 1–26).

The RVG revolutionised anaesthesia fees and rebates in Australia. Rather than basing anaesthesia fees and rebates on surgical item numbers and using an average anaesthesia time that was often incorrect, the RVG used anaesthesia specific items and actual anaesthesia time so as to tailor the anaesthesia account and rebate precisely to the anaesthesia provided.

[1] *Annual private health insurance statistics | APRA*. (2025, December 12). https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

The ASA RVG unit value is a suggested maximum monetary value that can be allocated to each ASA RVG unit. This indexed value is a cost-reflective benchmark and is designed to reflect the actual input costs of providing anaesthesia safely (e.g., staffing, indemnity, compliance, technology/equipment, practice overheads). It is a cost-based reference point intended to inform sustainable pricing and contracting.

The MBS RVG unit value on the other hand is a government-set dollar value per RVG unit that is used to calculate the Medicare benefit payable for relevant anaesthesia services. It is a public rebate parameter, reflecting Government indexation policy and budget settings rather than the full cost base of specialist practice.

In November 2001, the ASA RVG unit value was $50.50 per unit. When the MBS RVG unit value was introduced into the MBS for the first time that year, it was set at $17.15 per unit. While healthcare costs have continued to rise since then, both Medicare rebates and private health insurance benefits for anaesthesia services have failed to keep pace.

The Reserve Bank of Australia has an Inflation Calculator tool on its website[2] which calculates the change in the cost of purchasing a representative 'basket of goods and services' over a period of time. It is a simple but practical tool that shows how the purchasing power of money in Australia changes over time due to inflation. It does this by re-scaling historical dollar amounts using consumer price inflation, primarily the Australian Bureau of Statistics (ABS) consumer price index (CPI).

Had the MBS RVG unit value of **$17.15 in December 2001** been indexed in line with CPI, it would be **$32.87 by December 2025** – well above the current unit value of **$23.10**, illustrating the cumulative impact of sustained under-indexation.

It is also important to note that the ABS's consumer price index represents average household spending on a 'basket of goods and services' consisting of 11 major groups including housing, food, transport, education and health. Therefore, if a cost rises faster than household inflation (e.g. medical practice costs, wages, insurance, compliance), the CPI, and therefore the RBA calculator, will understate the real cost growth of that item. The ABS Health group CPI (which includes medical, dental and hospital services) has consistently outpaced headline CPI over long periods, including since 2001.

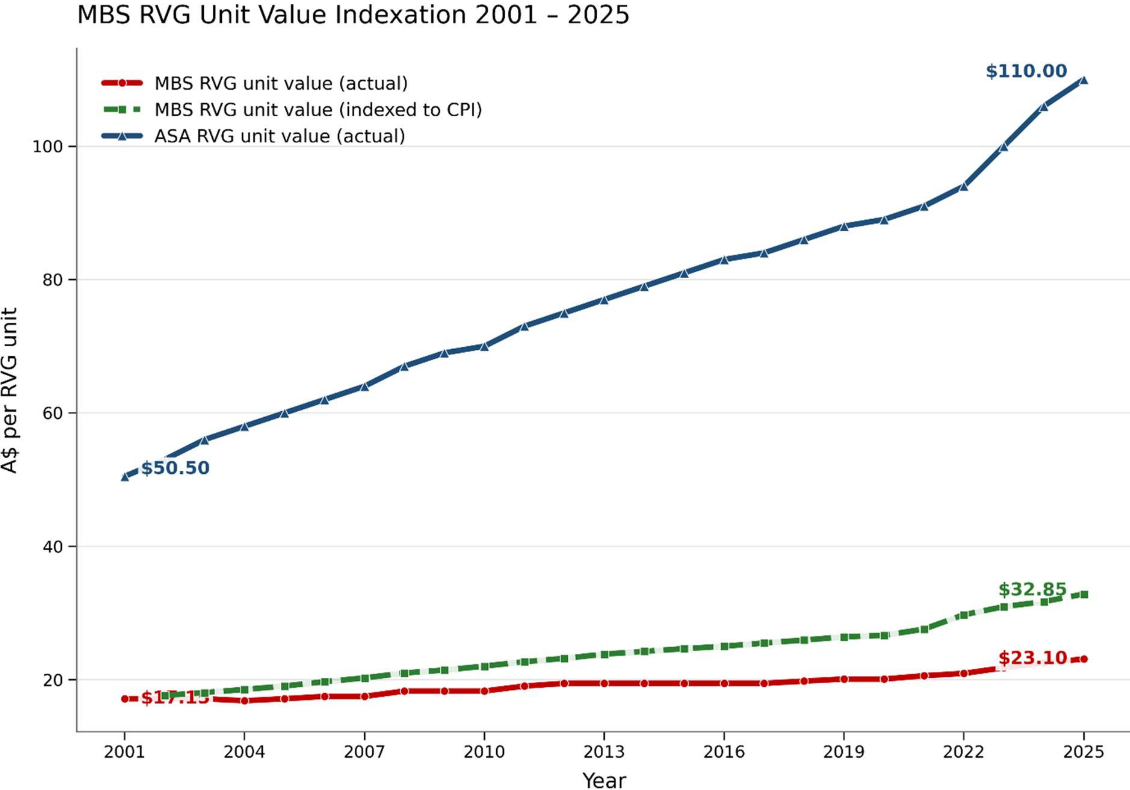
Between 2001 and 2025, the ASA RVG unit value has increased from $50.50 to $110 per unit (an increase of almost 118 per cent). This growth reflects rising practice costs, workforce pressures, equipment upgrades, compliance requirements, and broader inflation across the health sector. Over the same period, the MBS RVG unit value has increased far more modestly, from $17.15 to $23.10, an increase of only 35 per cent.

Notably, there was **no indexation** of MBS rebates between November 2012 and July 2019 (other than a 1.5 per cent indexation to attendance items on 1 July 2018). The current MBS RVG unit value of **$23.10** is only **21 per cent** of the current ASA RVG unit value which is **$110**.

When the Medicare RVG unit value grows more slowly than practice costs, and private health insurance benefits remain anchored to Medicare settings, the difference is shifted to patients (via increased gap or out-of-pocket costs) and/or absorbed by practices, creating sustainability risks.

[2] Reserve Bank of Australia. (2024). *Inflation Calculator* | *RBA*. Reserve Bank of Australia. https://www.rba.gov.au/calculator/

The graph below shows actual indexation of the MBS RVG unit value from 2001 to 2025 (red line). It also shows indexation of the MBS RVG unit value if it had been indexed to CPI (green line) and actual indexation of the ASA RVG unit value (blue line) over the same time period.



Private health insurer No-Gap and Known-Gap schemes

Private health insurance funds have similarly lagged, with funds' fee schedules falling well short of the ASA RVG recommended unit value. This under indexation has compounded, as private health insurance benefits are tied to the Medicare Schedule Fee, resulting in an even wider gap between rebates and actual costs.

The Health Legislation Amendment (Gap Cover Schemes) Act 2003 enabled private health insurers to introduce no-gap and known-gap schemes to reduce patient out-of-pocket costs. The 'gap' is the difference between what a medical practitioner charges a patient, and what Medicare and the private health insurer pay for that service. Under a no gap arrangement the patient incurs no out-of-pocket cost for the medical service – the medical practitioner accepts the Medicare rebate plus the private health insurer's top up payment as full payment. Under a known gap arrangement, the private health insurer pays a set amount above Medicare, and the medical practitioner may charge above this amount, but the patient's gap (out-of-pocket cost) is known and disclosed in advance (and is capped by the fund). Most major Australian health insurers cap the known gap at $500 per episode of care.

One issue that is often misunderstood is why insurer payments can suddenly drop back to the minimum level required by legislation. Known-gap limits have not been indexed at all since their

introduction, despite sustained growth in provider costs over this time. This happens because known-gap payments are voluntary and conditional, not guaranteed. Insurers agree to pay above the Medicare minimum only up to the fixed cap. Once a medical practitioner's fee exceeds that cap, the service no longer qualifies for the known-gap arrangement, and the insurer is only required to pay the statutory minimum – the 25 per cent top-up of the Medicare schedule fee.

While such instances remain relatively uncommon, the ongoing upward pressure on practice costs means that even modest, routine fee increases are increasingly likely to exceed the known-gap cap. When this occurs, costs are shifted back onto patients despite their private health insurance coverage. Compounding this issue, many insurers have moved away from applying known-gap limits on a per-item basis and now apply a single cap across the entire episode of care, encompassing all billed item numbers.

Our survey on Specialist Fees and Patient Out-of-Pocket Costs found that most anaesthetists (84 per cent) participate in no gap, known gap, or a combination of both arrangements with private health insurers. Among those who participate, the majority of private patients are billed under these arrangements, with known gap accounting for a larger share of patients than no gap. The survey also found participation in gap schemes is driven by patient financial considerations, alongside the practical benefits of simplifying billing and reducing the likelihood of disputes or delayed payment. Four in five respondents say they always or sometimes accept the known gap rebates, even when their fee is higher, suggesting they feel compelled to comply with private health insurer rules.

Table 2 demonstrates the scale of the funding gap between the current ASA RVG unit value and MBS and private health insurance rebates.

Table 2: RVG unit values – ASA benchmark vs MBS/DVA and selected private health insurer gap products (2024–2025)

Fund	2024 RVG unit value	2025 RVG unit value
ASA RVG unit value	**$106.00**	**$110.00**
MBS RVG unit value	$22.55	$23.10
Known gap products		
Medibank Private	$37.25	$38.15
AHSA	$37.56	$38.48
St Lukes	$38.80	$39.75
HCF	$37.20	$38.10
Bupa	$37.35	$38.25
NIB GapSure	$43.00	$43.00
No gap products		
HBF Full Cover	$35.85	$36.70
HCF	$38.35	$39.25
Bupa	$38.25	$39.15

On 1 November 2025, the ASA RVG unit value rose from $106 to $110 (+3.8 per cent), reflecting ongoing increases in the real cost of providing anaesthesia services. In contrast, the RVG unit values for Known gap and No gap products for some of the largest private health insurance funds in Australia remain clustered in a range between $37 and $43. Even the highest paid insurer product (NIB GapSure at $43) remains well below half the ASA RVG unit value of $110. Furthermore, the

MBS RVG unit value – currently just $23.10, continues to anchor the system at a low base (around one-fifth of the ASA benchmark) because many insurer products are explicitly or implicitly anchored to the MBS.

As Table 2 above shows, the inadequate indexation of Medicare and private health insurance anaesthesia rebates means they remain structurally misaligned with the real cost of care, entrenching a persistent funding gap that is absorbed by providers and/or shifted to patients and the public system.

The growing disparity between both Medicare and private health insurance rebates and the real costs of providing care creates significant challenges across the entire healthcare system. Patients face the prospect of increased out-of-pocket expenses, even when they hold private health insurance. Healthcare providers, such as specialist anaesthetists, are constantly faced with balancing the provision of quality care with covering rising operational costs.

Effect on the public health system

Persistent under-funding in both the public and private sectors creates workforce sustainability issues and service-coverage risks, particularly in rural, regional and outer-metro areas, further accelerating workforce maldistribution in these areas. Inadequate indexation of MBS and private health insurance rebates is also destabilising for high-acuity and complex care as well as after-hours, emergency and on-call work as clinicians withdraw from these rosters. This diminished 24/7 service coverage can increase reliance on locums, or ad-hoc arrangements that undermine continuity of care and patient safety.

Fair and regular indexation of both Medicare rebates and health fund benefits is essential to maintaining patient access to essential anaesthesia services in the private health care sector and supporting the sustainability of anaesthesia practices. Medicare rebates and health fund benefits that better reflect the real costs of providing anaesthesia services through appropriate indexation, help to ensure all Australians maintain access to quality anaesthesia care.

Anaesthetist Workforce Modelling Final Report

In April 2023, the ASA engaged HealthConsult to update our member survey and apply the new survey to gather data to inform the development of a workforce model for Australian anaesthetists over a ten-year horizon.

The profile, capability and needs of the health workforce including anaesthetists are being shaped by changes in health service models, not only due to Australia's growing and ageing population but also more recently due to the COVID-19 pandemic. Workforce modelling is essential to ensure that there is an appropriate, skilled workforce to meet the demand for anaesthetic services, now and in the future.

This project developed a workforce planning tool to estimate demand for, and supply of, the anaesthetic workforce between 2022 and 2032. The model can inform future planning for the anaesthetic workforce in Australia through its understanding of the composition and trends in the workforce and its subsequent projections of the likely changes in the supply of anaesthetists needed over 10 years to meet future service demands.

The modelling[3] projects a widening anaesthesia supply-demand gap to 2032, driven by rising demand, constrained working hours and impending retirements. Inadequate indexation of MBS fees and PHI rebates compounds these constraints by eroding real terms remuneration and practice viability, which reduces workforce participation and service availability, particularly for after-hours rosters, and in rural and regional settings, further amplifying the shortfall identified in our modelling.

Key findings

- Demand for anaesthetic services is expected to increase by 35.7 per cent between 2017 and 2032.
- The anaesthetist workforce in Australia is predicted to increase only 31.8 per cent in this time, from 4,594 to 6,055 anaesthetists.
- In 2027 there is estimated to be a 4 per cent shortfall gap between the forecast and required workforce.
- By 2032, the forecast workforce shortfall is expected to reach a 5.7 per cent.
- One fifth of anaesthetists are expected to retire within five years (National Health Workforce Dataset (NHWDS)).
- Anaesthetists' working hours are unlikely to match workload into the future.

The anaesthetist workforce model is fundamentally about capacity (how many clinicians, how many hours, where they work). Rebate adequacy and appropriate indexation are key levers that influences workforce participation, hours offered, and distribution across settings (public vs private; metro vs regional).

When MBS and private health insurance rebates are not indexed appropriately, the system tends to respond through reduced participation, reduced availability, and shift of activity, which further exacerbates the very supply-demand gap the model forecasts.

Our modelling indicates that clinicians are already signalling limited capacity or willingness to expand hours of work and, in fact, are more likely to reduce hours in the near future. In this context financial signals become even more important in preserving (not shrinking) the hours currently offered, especially in after-hours and high-acuity work.

Inadequate indexation of MBS and private health insurance rebates compounds the ASA's projected anaesthesia supply gap by weakening the supply response to rising demand, reinforcing constraints on working hours, and accelerating retirement decisions. By reducing the real value of anaesthesia work, particularly for complex care, after-hours and regional / outer metro services. Inadequate indexation also limits workforce participation and availability, meaning the behavioural constraints identified in the workforce modelling translate into greater access shortfalls and increased pressure on public hospitals through to 2032.

Anaesthesia Relative Value Guide Review

The ASA has recently commenced a comprehensive review of the Anaesthesia RVG in partnership with the Department of Health, Disability and Ageing (the Department). This review aims to

[3] Australian Society of Anaesthetists (ASA). (2024, August). *Anaesthetist Workforce Modelling Final Report* (HealthConsult), available at https://asa.org.au/wp-content/uploads/2024/08/Anaesthetist-Workforce-Modelling-Final-Report.pdf

modernise the RVG, reduce compliance risk, and ensure it remains fit for purpose and continues to reflect contemporary clinical practice. Importantly, this is **not a cost-cutting exercise**; and the Department has indicated that any identified savings are to be reinvested within the MBS Anaesthesia RVG.

Updating the MBS has traditionally been a complex process, involving lengthy submissions via the Medical Services Advisory Committee (MSAC) or MBS Review Advisory Committee (MRAC). It is worth noting the last significant review, the MBS Review Taskforce which ran from 2015–2020, did not deliver meaningful modernisation of the RVG. In fact, the initial recommendations of that review focused heavily on removing or devaluing many MBS anaesthesia RVG items.

Key principles of the current review, which have been agreed with the Department include updating item number descriptors and unit values, introducing new items for contemporary procedures, reducing ambiguity, reviewing time units, capturing public hospital activity, and addressing ASA items without MBS equivalents.

Updating the RVG, alongside education and compliance activity, remains the appropriate and proportionate approach to safeguarding the integrity of the MBS.

Conclusion

The Australian Society of Anaesthetists supports the intent of the Bill to improve choice and transparency for private health consumers. Done well, greater transparency can help patients navigate the private system and support informed financial consent. These reforms should be implemented with fit-for-purpose data definitions, appropriate consumer context, and a fast, simple and low-cost pathway for doctors to correct any inaccurate published information about them or their fees.

However, transparency alone will not resolve the structural drivers of rising out-of-pocket costs and access pressures. It must also be paired with funding settings that are cost-reflective and sustainably indexed, including predictable indexation of MBS anaesthesia rebates and private health insurer benefits, and indexation of known-gap limits.

Without this reform, the growing gap between rebates and the real cost of care will continue to undermine workforce participation – particularly for complex and acute care, after-hours rosters and rural, regional and outer metro services – and shift activity and demand to the already stretched public system.

The ASA welcomes ongoing consultation on implementation and would be happy to provide further evidence to the Senate Community Affairs Legislation Committee to support reforms that protect patients while maintaining safe, high-quality anaesthesia services for all Australians.

Contact the ASA

Matthew Fisher PhD DHlthSt (honoris causa)

Chief Executive Officer

Australian Society of Anaesthetists

P: 1800 806 654

E: policy@asa.org.au