Australian Society of Anaesthetists®

Australian Society of Anaesthetists

Specialist Fees & Patient Out-of-Pocket Costs Summary Report

Prepared by Survey Matters

March 2026

survey matters.

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Foreword

The conversation about specialist medical fees is often loud, but not always accurate. The Australian Society of Anaesthetists (ASA) has released this research examining how anaesthetists in private practice approach specialist fees, insurer arrangements, informed financial consent, and patient out-of-pocket costs.

Based on the insights from 1,121 specialists across Australia, this report provides a clearer picture of how these issues are experienced and managed on the ground, in real clinical settings. At a time when confusion around medical costs is growing, this report focuses on presenting the facts as they are.

The ASA was formed in 1934 and is a member-funded organisation dedicated to supporting, representing and educating anaesthetists to ensure the safest possible anaesthesia for the community. We have proudly supported 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 people at critical moments of their life and do so with great compassion, care and expertise. Australian anaesthetists are regarded as world leading for the standards of care and outcomes they provide on a daily basis in the Australian healthcare system. More than 7000 episodes of care are provided each day by Australian anaesthetists in the private system, and this provides significant insights into the patient journey.

This independent survey on Specialist Fees and Patient Out-of-Pocket Costs captured the experiences, insights, and concerns of approximately 24% of all registered anaesthetists who provide care through the private system and engage directly with patients and their families. Given it is a mixed public/private system in Australia, it is interesting to note that seventy percent of these specialists also provide care in the public system. This report provides direct clinician insights into the engagement with patients which is often the missing piece of narrative into specialist care.

The ASA strives to be an exemplary society of anaesthetists advocating for the specialty, patients, patient safety, and an accessible, equitable health system. This research builds on our Anaesthetist Workforce Modelling Final Report[1] launched at Parliament House, Canberra on 14th August 2024 that showed:

- The demand for anaesthetic services is expected to increase by 35.7% between 2017 and 2032.
- That 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).
- Anaesthetists' working hours are unlikely to match workload into the future.
- Addressing Australia's medical workforce challenges and access to care expected by Australians requires a multifaceted, collaborative, and whole of system approach.

The ASA is here to support anaesthetists practicing optimally on behalf of patients, their safety, and the health system.

Dr Vida Viliunas OAM
President

1. Available at https://asa.org.au/publications/anaesthetist-workforce-modelling

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Introduction

The 2026 ASA Specialist Fees and Patient Out-of-Pocket Costs research examined 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.

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

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

A total of 1,121 responses were received from anaesthetists working in private or mixed public-private practice, with results reported in aggregate to describe patterns and practices across different locations.

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Respondent Profile

A total of 1,121 responses were received, providing 95% confidence that actual results are within a +/- 2.6% confidence interval.

Anaesthetists who only worked in Public Hospital settings, or those based overseas, were screened out to ensure the survey captured only the opinions of anaesthetists who have appropriate knowledge of fee structures and patient out of pocket costs.

	Respondent Characteristics	%	n
State	ACT	3%	33
	NSW	29%	320
	NT	0%	5
	SA	7%	74
	QLD	20%	222
	TAS	2%	27
	VIC	30%	340
	WA	9%	100
Location	Metropolitan	79%	890
	Regional	20%	229
	Rural	0%	2
Practice Location	Exclusively Private Hospitals	30%	332
	Mix of Public & Private Hospital	70%	789
Provides obstetric services	Yes	56%	624
	No	44%	497
% Time spent in	Public Hospitals	36%	-
	Private Hospitals	64%	-

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Key Findings.

1.	**Anaesthesia fees are primarily driven by procedural factors and insurer arrangements** Fee setting is influenced by multiple factors, most commonly procedure duration and complexity, private health insurer gap arrangements, and the ASA or AMA RVG unit value benchmarks. Patient affordability considerations also play a material role in how fees are set in practice.
2.	**There is a consistent gap between current and preferred RVG unit rates** Across all States and Territories, anaesthetists report that the RVG unit rates they currently use are lower than the rates they desire by an average of $8.20. This gap is evident nationally, indicating a broadly shared view that current rates do not reflect contemporary practice.
3.	**Participation in private health insurer gap arrangements is widespread** Most anaesthetists participate in no gap, known gap, or a combination of both arrangements with private health insurers (84%). 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.
4.	**Patient financial considerations dominate participation, and many accept these arrangements even when usual fees are higher** Participation in insurer 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.
5.	**Informed financial consent is well established for planned admissions** 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.
6.	**Emergency and unplanned care presents constraints for informed financial consent** 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.
7.	**Fee reduction or waiving is a routine feature of anaesthesia practice** Requests to reduce fees are common, and 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 practice.
8.	**Rebate adequacy and indexation are seen as the primary levers to reduce patient out of pocket costs** When asked to identify actions that would most reduce patient out of pocket costs, anaesthetists consistently prioritise higher private health insurer rebates, increased Medicare rebates, and the indexing of known gap limits. Other measures, such as fee regulation or transparency initiatives, are viewed as secondary to addressing underlying legacy indexation and rebate issues.

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Summary
Results.

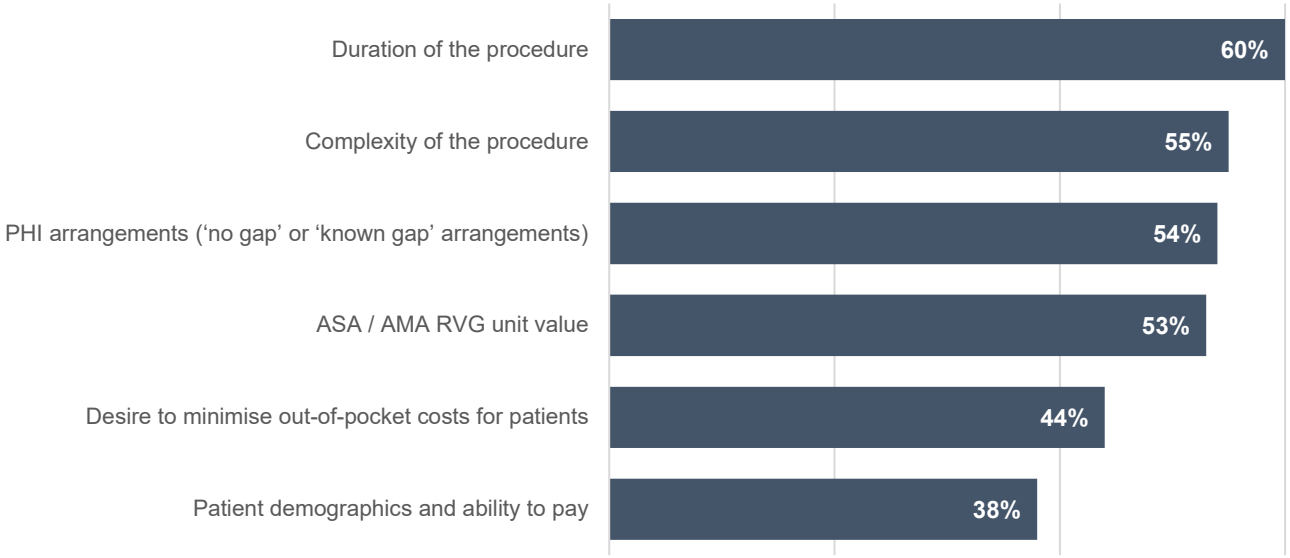
1. Factors Influencing Anaesthesia Fees

To understand fees settings, the survey asked the factors anaesthetists consider when deciding fees for private patients. It examined the influence of multiple factors on fee-setting practices.

Anaesthesia fees are driven by clinical and pricing considerations, with procedure duration, complexity, gap arrangements and the RVG unit value all influencing fees.

Overall, anaesthetists report that fees are influenced by a small group of inter-related factors, with duration of the procedure (60%), complexity of the procedure (55%), PHI gap arrangements (54%) and the ASA/AMA RVG unit value (53%) most commonly influencing fees.

Patient-facing considerations also feature, including minimising out-of-pocket costs (44%) and patient demographics and ability to pay (38%), suggesting fee setting reflects a balance between workload, benchmarks and affordability rather than a single dominant driver.



- Q9. Which of the following factors most influence how you set your anaesthesia fees for private patients: n=1121

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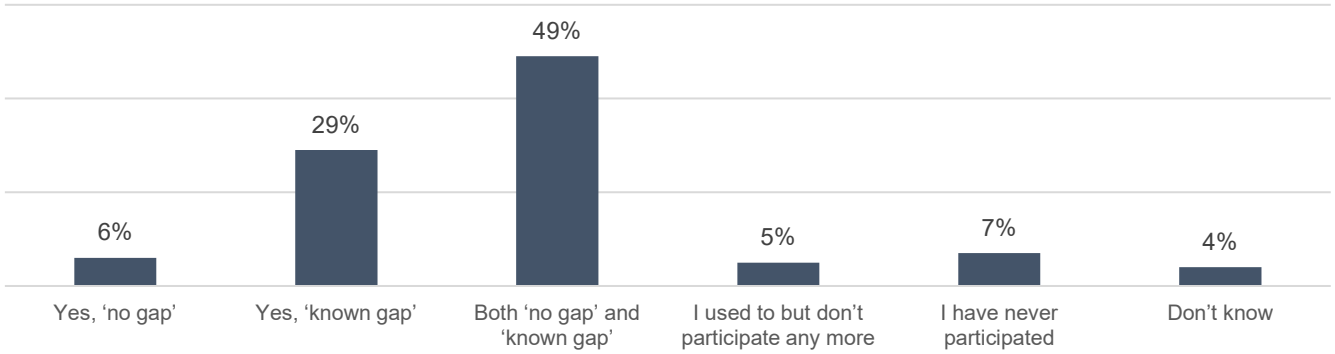
2. Participation in Gap Arrangements

The survey also sought to understand anaesthetists' participation in private health insurer no gap and known gap arrangements, the prevalence of these arrangements, how they are used in practice, and the factors influencing decisions to participate or opt out.

Most anaesthetists participate in private health insurer gap arrangements, though the type and extent of participation varies somewhat by location.

Overall, participation in gap arrangements is high, with the majority indicating they take part in either no gap, known gap, or both, most commonly through a combination of the two (49%). Exclusive participation in no gap arrangements remains relatively uncommon nationally (6%). These patterns indicate that while engagement with gap arrangements is widespread, the balance between no gap and known gap approaches reflects differing State practice norms and insurer environments.

Among anaesthetists who participate in gap arrangements, most of their patients are billed under these models, with known gap accounting for a larger share of patients than no gap overall.



- Q12. Do you participate in 'no gap' or 'known gap' arrangements with private health insurers (PHIs)? n=1121 Q16. What are the main reasons you participate in "No Gap" or "Known Gap" arrangements with PHIs? n=941 / Q17. What are the main reasons you opted-out or don't participate in "no gap" or "known gap" arrangements with PHIs? n=135

Reasons for Gap Participation

Participation in no gap and known gap arrangements is mostly driven by patient financial considerations, alongside the need to simplify billing and manage practical pressures in private practice.

Two thirds of anaesthetists participate in no gap or known gap arrangements because of patient financial considerations, followed by being able to simplify billing for patients (38%) and for the practice (26%), indicating that administrative and system pressures impact decision-making.

While there are some State-level differences in emphasis, overall the pattern suggests that participation is largely a pragmatic response to private health insurer rules and operating realities, rather than an endorsement of the rebates as adequate.

Reasons for Gap Non-Participation

Decisions not to participate in gap arrangements are driven primarily by concerns about inadequate rebates and the impact of insurer rules on clinical autonomy and standards of care.

Among the smaller group who do not participate in no or known gap arrangements, the dominant concern is that MBS and private health insurer rebates do not cover the cost of providing anaesthesia services (59%).

This is closely followed by concerns that preferred provider models and insurer controls undermine professional standards and clinical decision-making (50%).

Collectively, these responses indicate that opting out is less about selectively treating private patients and more about fee structures and provider arrangements that respondents view as financially unsustainable and impacting standards of clinical practice.

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Effects of PHI Arrangements on Fees

Free-text feedback highlights widespread frustration with unindexed rebates and insurer rules that shift financial pressure onto patients and distort anaesthetists' fees.

Insurer behaviour is frequently described as rigid and punitive, with rules that reduce patient rebates when fees exceed caps, increasing patient out-of-pocket costs while positioning anaesthetists as responsible for gaps created by insurer settings.

Comments about PHI arrangements and their effects highlighted five topics.

1. **Lack of Indexation:** Respondents consistently report that Medicare and private health insurance rebates, including the $500 known gap, have not kept pace with inflation for many years. This erosion in real value is seen as undermining the sustainability of known gap arrangements and distorting fees over time.
2. **Patient Affordability:** Many respondents emphasise a strong desire to minimise patient out-of-pocket costs, particularly for vulnerable groups and those facing cost-of-living pressures. However, they note that inadequate rebates increasingly force a trade-off between affordability for patients and financial viability for practices.
3. **Private Health Insurer Behaviour:** Private health insurers are widely perceived as using rigid caps, punitive rebate reductions and opaque rules that shift costs onto patients while positioning clinicians as responsible for gaps. Respondents describe these practices as anti-competitive, misleading for patients, and primarily driven by insurer cost containment rather than patient care.
4. **Impacts to Remuneration & Practice Costs:** Respondents highlight rising practice expenses, including staffing, insurance and compliance, alongside declining real remuneration due to poor indexation.
5. **Impacts on Long / Complex Procedures:** Longer and more complex procedures are repeatedly identified as poorly accommodated by flat rebate structures and the fixed $500 known gap. Respondents report that these cases often become financially unviable under existing arrangements.

Q19. Do you have any other comments regarding PHI arrangements and how these affect your fees? n=534 comments

"Essentially unfair pay system that is not indexed and does not pay us anywhere near what we should be getting especially for bigger cases.

The insurers are using this to label anaesthetists as greedy when the actual fact is that our reimbursements have not kept up with inflation, nor costs, whilst insurance companies are posting record profits."

Respondent, Victoria

3. Informed Financial Consent

How informed financial consent (IFC) is provided to patients in both planned and unplanned care settings was explored to understand who provides consent information, how it is communicated, and the practical constraints that affect consent processes in emergency and time-critical situations.

Planned Admissions

In planned admissions, informed financial consent is usually managed by anaesthetic practices and communicated in writing.

In planned admissions, responsibility for informed financial consent most often sits with the anaesthetist's practice (68%) and is communicated by either email or mail (83%), indicating consent processes are well established.

Who provides IFC to patients	Total
Sample	1121
Done by the practice I am a part of	68%
Through my billing software	21%
I do this myself	21%
Outsourced to 3rd party billing provider	13%
Through the surgeon/proceduralist	10%
Through the hospital	1%

How is IFC communicated	Total
Sample	1121
Written estimate is sent via email or mail	83%
SMS	36%
Verbal discussion	29%
Automated through my billing software	22%
Through the surgeon/proceduralist	11%
Through the hospital	1%

Unplanned Admissions

In unplanned and emergency admissions, informed financial consent is most often provided verbally at the time, with limited opportunity for written communication.

Informed financial consent is commonly delivered verbally at the time of care (69%), reflecting the time-critical and clinically focused nature of these situations.

For unplanned obstetric admissions, the pattern is similar, with verbal consent at the time most common overall, reinforcing the practical and ethical constraints on providing comprehensive financial information in urgent clinical settings.

Written comments about communications in unplanned obstetric admissions indicated either that respondents don't do emergency obstetrics, or that they always use no gap arrangements in these circumstances.

IFC in unplanned admissions	Total
Sample	1121
Verbal at the time	69%
IFC is provided as follow up afterwards	26%
Email at the time	10%
Written information at the time	9%
Other	19%

IFC in unplanned obstetric admissions	Total
Sample	624
Verbal at the time	46%
Provided as follow up afterwards	17%
Written information at the time	7%
Provided separate to the epidural attendance	7%
Email at the time	1%
Other	23%

- Q19. Who provides Informed Financial Consent to your patients? n=1121 / Q20. How is Informed Financial Consent communicated to your patients for a planned admission? n=1121 Q21. How is Informed Financial Consent communicated to your patients for unplanned / emergency admissions? n=1121 / Q22. How is Informed Financial Consent communicated for unplanned / unscheduled obstetric admissions? n=624

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"I generally no-gap these patients as I feel it is complex providing adequate IFC and to reduce patient distress."

Respondent, NSW

In unplanned and emergency settings, informed financial consent is often managed by defaulting to no gap or known gap billing, reflecting discomfort with fee discussions and ethical concerns about patient vulnerability.

Free-text responses consistently describe unplanned admissions as situations where time pressure, patient distress and limited choice make meaningful fee discussions difficult, leading many anaesthetists to avoid the issue by no-gapping or using known gap arrangements. Others report that while most patients ultimately understand and accept fees, clinicians remain uneasy about discussing costs immediately before urgent care, with ethical concerns about consent and coercion frequently cited as reasons for waiving or reducing fees.

Four common themes around communication of informed financial consent emerged:

1. **Usually avoided by using No Gap or Known Gap**

Many respondents say they minimise IFC complexity in urgent settings by defaulting to No Gap or Known Gap billing, often because there is limited time to provide written consent. This approach is described as a practical way to reduce patient stress, complaints and non-payment risk in unplanned care.

2. **Difficulty / awkwardness discussing fees in emergency situations**

Respondents frequently describe fee conversations in emergencies as uncomfortable, rushed and poorly timed, with clinical priorities and patient distress taking precedence. Several comments note that IFC in the anaesthetic bay or immediately pre-procedure can feel inappropriate and difficult to deliver meaningfully.

3. **Patients generally understand / pay fees**

Many respondents report that most patients accept there may be an out-of-pocket cost in private emergency settings, particularly when the fee is modest, capped, or communicated simply.

4. **Ethical concerns about charging gaps**

Respondents also raise concerns about patient vulnerability and limited choice in unplanned admissions, with some describing gap charging as coercive or inconsistent with genuine informed consent. This discomfort often drives decisions to waive or reduce gaps.

Q23.What is your typical experience in the communication of IFC for unplanned / unscheduled admissions? n=826 comments

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Obtaining IFC from Patients

Informed financial consent is mostly obtained once operating lists or patient details are received, rather than during clinical consultations or on the day of surgery.

Across the sample, informed financial consent is overwhelmingly obtained when operating lists or patient details are provided (91%), indicating that IFC is largely embedded in administrative workflows.

Very few respondents report obtaining informed financial consent on the day of the procedure or afterwards, reinforcing that most anaesthetists aim to finalise financial discussions before the point of care, when time pressure and patient vulnerability is high.

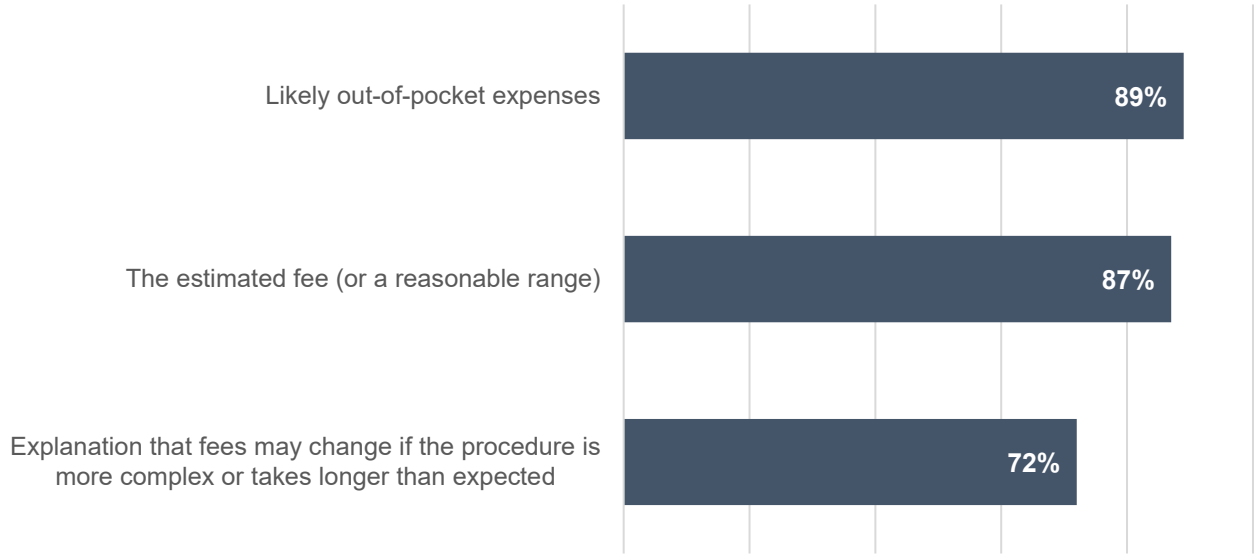
91%

Of responding anaesthetists seek IFC when the operating list / patient details are provided

Information Included in IFC to Patients

Most anaesthetists include clear fee estimates and likely out-of-pocket costs in informed financial consent.

The majority report including core financial information, particularly likely out-of-pocket expenses (89%) and an estimated fee or range (87%). Around seven in 10 also include information about changes in fees should the circumstances of the procedure change.



- Q24. At what stage do you primarily obtain informed financial consent from your patients? n=1121 / Q26. Do you require written acceptance from the patient for the estimated fees and out-of-pocket expenses before the day of the procedure? n=1121 / Q27. When providing information for Informed Financial Consent, do you include the following information? n=1121

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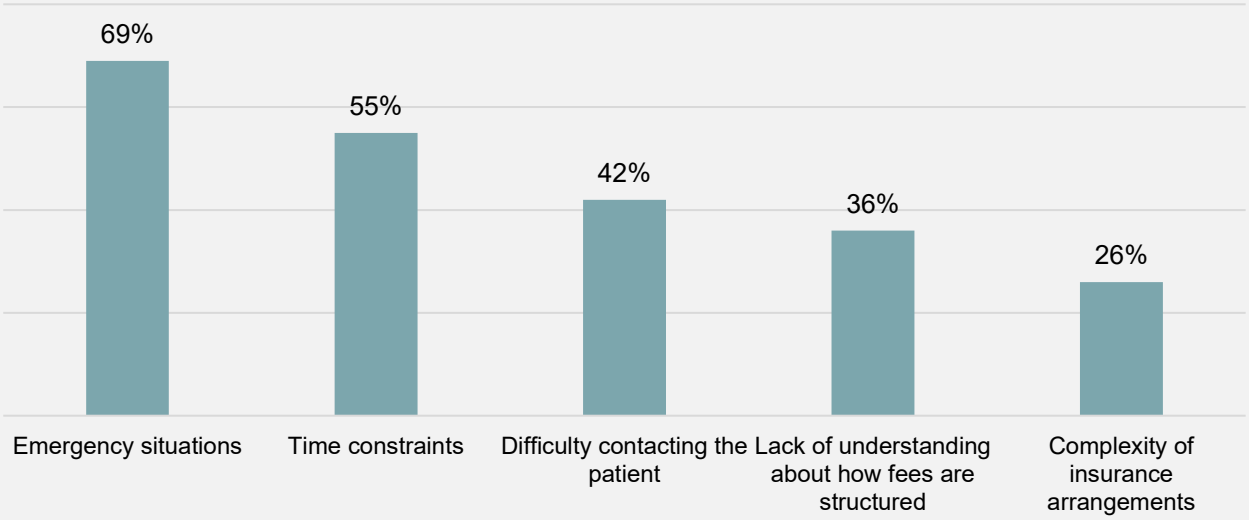
Barriers to Obtaining IFC

Emergency care and time pressures are the main barriers to obtaining informed financial consent.

The biggest barrier to obtaining informed financial consent is emergency situations (69%), followed by cases being booked close to the procedure date (55%) and difficulty contacting patients beforehand (42%), highlighting the practical constraints rather than lack of intent or process. Issues such as fee structure complexity (36%) and insurance complexity (26%) also feature, indicating that system design also contributes to difficulty.



Q28. What are the main barriers, if any, for you obtaining Informed Financial Consent in accordance with ASA guidelines? n=1121

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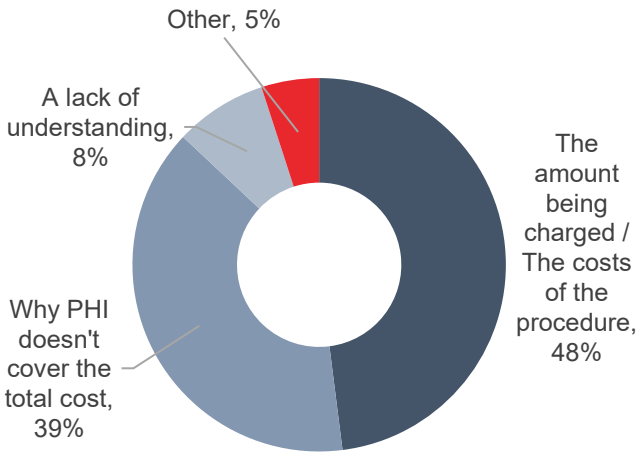
4. Patient Considerations

The final part of the survey focused on patient-related issues associated with anaesthesia fees and out-of-pocket costs. It looked at experiences with patient complaints, requests for fee reduction or waiving, and views on what may assist patients to better understand fees and insurance rebates.

Patient Complaints

Patient complaints about out-of-pocket fees are relatively uncommon, and when they do occur, they are most often directed at the size of the fee or gaps in insurance coverage rather than a lack of understanding.

A third of respondents report receiving any patient complaints about out-of-pocket fees in the past 12 months (36%), indicating that complaints are not a routine feature of practice for most anaesthetists.



Reducing or Waiving Fees

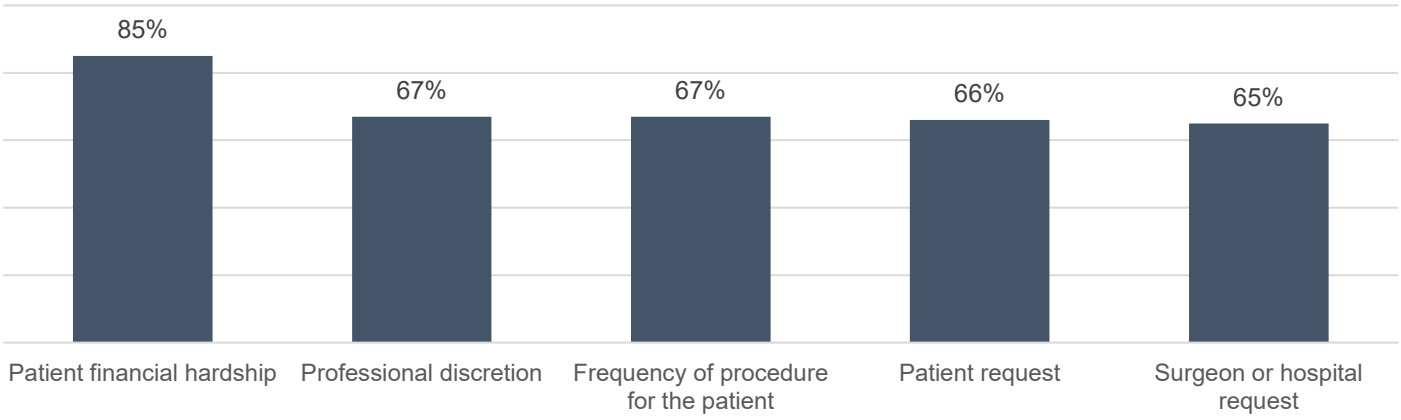
Requests for fee reduction are common, and most anaesthetists report waiving or reducing fees at least occasionally as part of routine practice.

Around seven in 10 (72%) of respondents report receiving requests to reduce their fees in the past 12 months, indicating that fee negotiation has become a common practice for anaesthesia procedures.

Decisions to reduce or waive fees reflect a combination of patient circumstances, professional judgement and external requests, rather than a single dominant factor.

When deciding whether to reduce or waive fees, respondents report weighing multiple factors. While patient financial circumstances are the primary driver, other factors are of similar importance, including professional discretion, frequency of procedure, patient requests, and requests from surgeons or hospitals.

Patient complications also influence decisions for around half of anaesthetists, reinforcing the role of clinical context alongside financial considerations.



• / Q30. In the past 12 months, have you received patient complaints about out-of-pocket fees? n=1120 / Q31. Are those complaints usually about: n=400 / Q33. In the past 12 months, have you received any requests to reduce your fees? n=1120 / Q35. What factors do you take into consideration when waiving or reducing your fee? n=1121

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Helping Patients Understand Fees & Out-of-Pocket Costs

Respondents believe better transparency from health funds and clearer education about rebates would do most to improve patient understanding of fees and out-of-pocket costs.

Free-text feedback consistently points to a need for greater transparency from private health insurers and clearer education about how Medicare and insurance rebates work, with many respondents arguing that patients wrongly assume insurance should cover the full cost of care. Calls for improved indexation and rebate settings sit alongside requests for simple, standardised educational materials, reflecting a view that better information and clearer explanations would reduce confusion and mistrust directed at clinicians.

Respondents identified four ways to help patients understand fees and out-of-pocket costs.

1. **More Transparency from Health Funds:** Respondents call for private health insurers to be clearer and more honest about what they do and do not cover, including how and why rebates are reduced. Many believe clearer disclosure from funds would correct misconceptions that out-of-pocket costs are driven by clinicians rather than insurer policy settings.

2. **Education on Medicare and Insurance Rebates:** A dominant theme is the need for patients to better understand that Medicare and private health insurance rebates are subsidies, not full coverage, and that they have not kept pace with real costs. Respondents note that clearer education would help patients distinguish between a clinician's fee and the rebate decisions made by government and insurers.

3. **Indexation and Rebate Adjustments:** Many respondents emphasise that long-term failure to index Medicare and private health insurance rebates, including known gap limits, is central to rising out-of-pocket costs. They believe patients would be more accepting of fees if the impact of poor indexation and stagnant rebates were explained plainly and consistently

4. **Educational Guides, Statements and Information:** Respondents also suggest simple, standardised resources such as fact sheets, worked examples, infographics or ASA-endorsed guides to explain fees and rebates.

Q32. In your opinion, what would help patients better understand about fees and out of pocket costs for their treatment? n=777 comments

"Patients would benefit from a clearer understanding that professional fees are set independently of insurance rebates, which are merely subsidies that have failed to keep pace with the actual costs of providing specialist care..."

Respondent, NSW

About

About the Australian Society of Anaesthetists

Formed in 1934, the Australian Society of Anaesthetists is a not-for-profit, member-funded organisation dedicated to supporting, representing and educating anaesthetists to ensure the safest possible anaesthesia for the community. We have proudly supported 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.

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About Survey Matters.

Survey Matters work exclusively in the association and for purpose sector. Specialising in providing strategic research led services to membership and not-for-profit organisations, we have helped a wide range of organisations understand their value proposition. We also work with the sector to generate and build industry data and knowledge to support advocacy, promotion, industry development and marketing activities.

If you would like to know more about this report or the work we do, please get in touch.

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