

House Standing Committee on Health, Aged Care and Disability

# **INQUIRY INTO ACCESS TO AND AFFORDABILITY OF MEDICAL SPECIALISTS IN AUSTRALIA: SUBMISSION**



Australian Society of  
**Anaesthetists®**



Australian Society of  
**Anaesthetists®**

## ABOUT THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

The **Australian Society of Anaesthetists (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.

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# EXECUTIVE SUMMARY

Patients' out-of-pocket costs reflect how specialist care is funded, organised and delivered. Improving access and affordability therefore requires coordinated action across specialist workforce capacity, referral pathways, hospital and supporting services, Medicare benefits, private health insurer benefits, specialist fees and patient information.

Anaesthetists enable surgery and support emergency, maternity and other complex care across public and private settings. The time, complexity and resources required vary between patients and procedures. The Australian Society of Anaesthetists (ASA) welcomes the Committee's focus on improving access to affordable specialist care and supports reforms that give patients timely treatment, clear information about costs and meaningful support from Medicare and private health insurance.

Public and private services draw on a shared specialist workforce and serve the same communities. Changes to funding, workforce participation or service availability in one part of the system can affect access, waiting times and capacity elsewhere. Reform should therefore be assessed across the full patient pathway – from referral and specialist assessment to preparation, treatment and follow-up.

## CLOSING THE FUNDING GAP

A specialist's fee and a patient's out-of-pocket cost are related, but they are not the same. For insured in-hospital medical care, the patient's gap reflects the difference between the specialist's fee and the combined Medicare and private health insurer benefits. For out-of-hospital specialist consultations, patients generally rely on Medicare because private health insurance generally cannot cover the medical gap.

When Medicare benefits, private health insurer benefits and known-gap limits do not maintain their relative value, a greater share of the cost may be absorbed by patients or practices. Affordability reform should therefore examine the whole funding chain, including the adequacy, design and indexation of Medicare and insurer benefits, gap-scheme rules, professional costs, specialist fees and patient contributions. Fee transparency and informed financial consent are important, but they cannot remedy an underlying funding shortfall.

The ASA's 2026 Specialist Fees & Patient Out-of-Pocket Costs survey<sup>1</sup> received 1,121 responses from anaesthetists working in private or mixed public–private practice. It found that fee setting reflects procedure duration, clinical complexity, insurer arrangements, relevant professional fee guidance and patient circumstances. Most respondents participated in private health insurer no-gap or known-gap arrangements.<sup>2</sup> These findings demonstrate that anaesthesia fees and patient gaps arise from multiple interacting factors rather than a single pricing decision.

The financial pressure on patients is clear. The Department of Health, Disability and Ageing reports that Australians paid \$4.17 billion out of pocket for out-of-hospital specialist services in 2025.<sup>3</sup> It also cites Australian Bureau of Statistics data showing that 8.6 per cent of people aged 15 years and over – more than 1.9 million Australians – delayed or did not see a specialist because of cost in 2024–25.<sup>4</sup> For regional and remote patients, medical costs may be compounded by travel, accommodation, time away from work and limited local services.

## MAKING SPECIALIST CARE AVAILABLE

Access depends on more than the number of registered specialists. It depends on whether clinicians are available where and when patients need them and whether they are supported by outpatient services, diagnostics, operating theatres, beds, nursing and allied health teams, effective referral pathways and appropriate escalation arrangements. The ASA describes this as effective specialist capacity.

The ASA's Anaesthetist Workforce Modelling Final Report forecasts that demand for anaesthesia services will increase by 35.7 per cent between 2017 and 2032, compared with projected workforce growth of 31.8 per cent. Under the base scenario, demand is projected to exceed supply by 224 anaesthetists in 2027 and 343 in 2032. If average workload falls by 2.5 per cent, the projected shortfall increases to 507 anaesthetists by 2032.<sup>5</sup>

Australia needs nationally coordinated workforce planning, additional funded training and supervision, sustainable regional training networks and flexible Staff Specialist, Visiting Medical Officer, part-time and mixed public–private arrangements. The ASA recommends funding at least 50 additional anaesthesia trainees each year, with one-third undertaking training in regional and rural Australia.

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1 Australian Society of Anaesthetists, *Specialist Fees and Patient Out-of-Pocket Costs: Summary Report* (April 2026), p. 7. available at <https://asa.org.au/wp-content/uploads/2026/04/ASA-Specialist-Fees-Patient-Out-of-Pocket-Costs-Summary-Report.pdf>

2 Ibid. p. 8.

3 Australian Government Department of Health, Disability and Ageing, *Specialist Affordability: Options to Address Excessive Fee Charging* (Consultation Paper, 2026), p. 2.

4 Ibid, 13.

5 Australian Society of Anaesthetists, *Anaesthetist Workforce Modelling Final Report* (2025), <https://asa.org.au/wp-content/uploads/2024/08/Anaesthetist-Workforce-Modelling-Final-Report.pdf>.

Referral reform should give patients and referrers timely information about referral receipt, triage status, indicative waiting periods, next steps and clinically appropriate alternatives. Where care crosses providers or public and private settings, responsibility for assessment, information transfer, treatment, follow-up and escalation must remain clear.

If patients cannot access or afford private treatment, some may defer care or seek treatment through already constrained public services. Conversely, limited public capacity can leave patients choosing between a prolonged wait and private treatment they struggle to afford. Strategic use of public and private capacity may improve access, but it must complement sustained public investment and protect continuity, training, clinical governance and patient safety.

## **ADDRESSING EXCESSIVE FEES FAIRLY AND PROPORTIONATELY**

The ASA supports ethical, reasonable and transparent fee setting and does not support excessive or egregious charging. The Department's analysis indicates that only a small minority of services are charged substantially above the median for the same item<sup>6</sup>. It also identifies limitations in defining excessive fees solely by reference to MBS Schedule Fees, medians or percentile thresholds.

For anaesthesia, reliable assessment requires an understanding of procedure duration, patient complexity, time and modifier items, co-claimed services, insurer arrangements and the complete episode of care. An apparent item-level outlier may not represent an excessive total fee if the data do not capture the full service or the allocation of the patient's out-of-pocket cost across billed items.

Responses should therefore be specialty-specific, staged and proportionate. Governments should use complete episode-level data, accurate information, confidential provider feedback, education and peer-informed review, while retaining investigation and enforcement for clearly egregious conduct. Any framework should protect patients' Medicare benefits, provide appropriate remediation and monitor effects on provider participation, regional access, complex and after-hours care, cost-shifting and public hospital demand.

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<sup>6</sup> Department of Health, Disability and Ageing, Specialist Affordability, p. 7-8.

## PRIORITIES FOR REFORM

The ASA recommends a coordinated reform program that:

1. **Develops and funds a nationally coordinated specialist workforce strategy based on** projected demand and effective specialist capacity, including at least 50 additional anaesthesia trainees each year and sustainable regional training, supervision and retention measures.
2. **Establishes nationally consistent requirements for referral transparency and continuity of care**, supported by interoperable systems and clear allocation of clinical responsibility across public and private settings.
3. **Commissions an independent review of Medicare and private health insurer benefit settings**, including MBS anaesthesia benefits, insurer schedules, known-gap limits, episode-level caps and other scheme rules affecting patient costs and provider participation.
4. **Requires integrated financial transparency before planned care**, including clear information about provider fees, Medicare and insurer benefits, gap arrangements, eligibility criteria, likely out-of-pocket costs and material differences in benefits across products, hospitals and treatment pathways.
5. **Establishes a specialty-specific, staged and proportionate framework for excessive charging**, based on complete episode-level evidence, patient protections and monitoring of unintended consequences.
6. **Aligns service-capacity investment, emerging models of care and national data**, including investment in clinics, theatres, beds and supporting teams; appropriately governed regional, digital and shared-care models; strategic use of public–private capacity; and evaluation against access, safety, equity, treatment completion and system demand.

The ASA's detailed recommendations are set out in section 6.

The test of reform should be whether patients can progress safely and promptly from referral to treatment at a cost they can afford. Meeting that test requires shared responsibility across the Australian Government, state and territory governments, health services, private health insurers, hospitals and the medical profession. Reform should expand effective specialist capacity, ensure that Medicare and insurer benefits provide meaningful support, strengthen patient information and continuity, invest in the service capacity needed to deliver care, evaluate emerging models against measurable outcomes and address genuinely excessive conduct proportionately.

The ASA would welcome the opportunity to discuss this submission with the Committee.



# 1. CURRENT ACCESS TO MEDICAL SPECIALISTS



Examine current access to medical specialists in cities, regional and rural communities, with consideration of workforce distribution, shortages, waiting times and barriers to recruitment, retention and training.

## 1.1 ASA ANAESTHETIST WORKFORCE MODELLING FINAL REPORT

The ASA commissioned HealthConsult in 2023 to update the evidence base for national anaesthesia workforce planning, as the previous Australian Government modelling had been published in 2016 using predominantly 2014 data. The completed model examined the projected supply of and demand for anaesthetists from 2022 to 2032, drawing principally on an updated ASA member survey and available national workforce and trainee data. It identified the likely scale and drivers of future workforce pressures and provides an evidence base for planning workforce supply, training capacity and service availability over the decade.<sup>7</sup>

## 1.2 AUSTRALIA FACES A GROWING ANAESTHESIA CAPACITY CHALLENGE

Australia needs a specialist workforce that can meet both current and future demand.

The ASA's national workforce modelling forecasts that demand for anaesthetic services will increase by 35.7 per cent between 2017 and 2032. Over the same period, the anaesthetist workforce is projected to increase by 31.8 per cent, from 4,594 to 6,055 anaesthetists.<sup>8</sup>

Under a base scenario, the required workforce is projected to exceed forecast supply by:

- 224 anaesthetists in 2027, representing a 4.0 per cent shortfall; and
- 343 anaesthetists in 2032, representing a 5.7 per cent shortfall.<sup>9</sup>

The workforce modelling identified a structural trend towards lower average working hours. This was supported both by anaesthetists' stated future intentions and by historical national workforce data, including evidence that younger anaesthetists are working fewer hours than their predecessors. While

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<sup>7</sup> Australian Society of Anaesthetists, Anaesthetist Workforce Modelling Final Report, p. 1.

<sup>8</sup> Ibid. 3.

<sup>9</sup> Ibid. 22-23

part of the reduction reflects an ageing workforce moving towards retirement, the evidence suggests the trend is broader than retirement alone.<sup>10</sup>

The modelling therefore assumed a modest 2.5% reduction in average workload (or one hour per week in a 40-hour week), which increases the projected anaesthetist shortfall from 343 to 507 by 2032.<sup>11</sup>

These projections demonstrate why workforce planning must assess effective specialist capacity, not simply the number of registered anaesthetists. Effective capacity is the amount of clinical care the workforce can provide, taking account of full-time-equivalent participation, hours worked, retirements and workforce exits, geographic distribution, availability for after-hours and complex care, training and supervision capacity, participation across public and private settings, and the clinical infrastructure required to deliver services.

Consistent with the objectives of the 2026–31 National Health Reform Strategy and National Health Reform Agreement<sup>12</sup>, Commonwealth, state and territory governments should align specialist workforce planning with investment in public hospital capacity. For anaesthesia, this should include funded training positions, sufficient supervisory capacity, sustainable regional training networks and flexible employment arrangements across public and private settings. The policy objective should be to increase the specialist capacity available to patients, rather than specialist headcount alone.

## 1.3 GEOGRAPHIC DISTRIBUTION REMAINS A MAJOR CHALLENGE IN AUSTRALIA

Increasing the national supply of anaesthetists will not, by itself, correct regional and rural workforce maldistribution. Previous ASA work identifies four interrelated barriers to recruitment and retention<sup>13</sup>:

- **Workload and employment conditions**, including substantial on-call requirements and limited leave or replacement cover
- **Professional support**, including access to continuing education and relief from professional isolation
- **Clinical infrastructure**, including intensive care, subspecialty and broader specialist backup; and
- **Family and community considerations**, including employment and education opportunities for family members.

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<sup>10</sup> Ibid. 3.

<sup>11</sup> Ibid. 3.

<sup>12</sup> Health Ministers' Meeting, 2026–31 National Health Reform Strategy (endorsed 4 September 2026).

<sup>13</sup> See for example, Australian Society of Anaesthetists, *Submission to the Special Commission of Inquiry into Healthcare Funding in New South Wales* (November 2023), <https://asa.org.au/wp-content/uploads/2024/08/ASA-Special-Commission-of-Inquiry-into-Healthcare-Funding-in-NSW-Submission-November-2023.pdf>

Regional workforce policy should address these conditions as a coordinated package rather than rely principally on financial incentives. Governments and health services should support sustainable workloads, competitive employment arrangements, continuing professional development, appropriate relief and backfill, dependable clinical networks and the infrastructure needed to practise safely. These measures are necessary to attract specialists to regional communities and, critically, to retain them.

## 1.4 EXPAND FUNDED SPECIALIST TRAINING CAPACITY

The ASA's Anaesthetist Workforce Modelling Final Report recommends employing at least 50 additional anaesthesia trainees each year, with one-third undertaking training in regional and rural Australia.<sup>14</sup> This expansion must be supported by funded employment positions, sufficient specialist supervision, appropriate case volume and complexity, access to required subspecialty experience, accredited training environments and the hospital capacity needed to deliver training.

ASA member feedback indicates that some regional training opportunities are constrained by inadequate funding or supervisory capacity, even where accredited or potentially suitable training environments exist. Governments should therefore invest in sustainable regional training networks rather than rely on numerical placement targets alone, ensuring that trainees can complete the required breadth of experience while strengthening the longer-term regional workforce pipeline.

## 1.5 TRAINING CAPACITY DEPENDS ON FUNDED HOSPITAL POSITIONS

There is a common belief that specialist medical colleges control how many doctors are trained in a particular specialty in Australia. In anaesthesia, this is not correct.

Anaesthesia training capacity is principally determined by the number and location of funded hospital training positions, rather than by a numerical limit imposed by the Australian and New Zealand College of Anaesthetists (ANZCA). State and territory governments, public hospitals and health services fund and employ trainees according to workforce plans, service demand and available hospital capacity. Doctors must first secure employment in a funded position before registering with ANZCA as trainees.

ANZCA sets training and supervision standards, accredits training hospitals and networks, establishes the curriculum and assesses trainees. It does not fund training positions, employ trainees or appoint registrars. Expanding the anaesthesia workforce therefore requires government-led workforce planning, additional funded positions, sufficient supervisory capacity and appropriate hospital infrastructure. ANZCA determines the standards by which anaesthetists are trained; governments and health services determine how many funded training opportunities are available.

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<sup>14</sup> Australian Society of Anaesthetists, *Anaesthetist Workforce Modelling Final Report*, p. 2.

## 1.6 USE FLEXIBLE EMPLOYMENT MODELS TO RETAIN EXISTING SPECIALIST CAPACITY

Governments and health services should make better use of anaesthetists already working across Australia's interconnected public and private health systems. Flexible Staff Specialist, Visiting Medical Officer (VMO), part-time and mixed public-in-private arrangements can retain specialist participation in public services and increase the clinical capacity available to patients.

No single employment model will suit every service. Arrangements should reflect local demand, available infrastructure, on-call requirements and the need for continuity, training and a stable specialist presence. In regional areas, this may include enabling locally based private specialists to provide regular public hospital services as VMOs, reducing unnecessary reliance on transient workforces. Governments should avoid rigid employment models that require specialists to choose between full-time salaried employment and leaving the public system where more flexible arrangements could retain valuable capacity.

## 2. REFERRAL PATHWAYS

Examine the effectiveness, transparency and equity of referral pathways from the perspective of patients, primary health care practitioners and medical specialists across the public and private health sectors, with consideration of factors affecting referral patterns and any systemic, regulatory or administrative barriers to the appropriate utilisation of these pathways.

### 2.1 ASSESS REFERRAL PATHWAYS BY WHETHER THEY LEAD TO CARE

Assessment of referral pathways should extend beyond whether a referral is successfully transmitted from primary care to a specialist. For procedural specialties, an effective pathway may encompass:



ASA member feedback identifies limited visibility of referral status, uncertainty about expected waiting periods and next steps, and difficulty for patients and referring practitioners in understanding clinically appropriate public and private options.

Greater transparency should help patients and practitioners navigate the pathway while preserving clinical need and urgency as the basis for prioritisation.

### 2.2 PROVIDE PATIENTS AND REFERRERS WITH MEANINGFUL PATHWAY INFORMATION

Patients and referring practitioners should receive timely confirmation that a referral has been received, its triage status, an indicative waiting period, the next expected step and any clinically appropriate alternatives. They should also be notified if a referral is rejected, redirected or cannot be progressed without further information. Waiting-period information should be clearly identified as indicative and should not displace prioritisation according to clinical need.

Governments and health services should support consistent referral-status notifications and interoperable systems that allow referring practitioners to monitor progress and manage patients safely while they wait.

Where private care is being considered, referral information should also support access to accurate and appropriately contextualised information about fees, benefits and likely out-of-pocket costs. Price information should not imply that higher fees necessarily indicate higher clinical quality.

## **2.3 PRESERVE CLINICAL RESPONSIBILITY WHEN CARE CROSSES SECTORS**

Referral reform must preserve continuity when patients move between providers or between public and private settings. Cross-sector pathways should clearly allocate responsibility for pre-treatment assessment, transfer of clinical information, access to records, postoperative care, escalation and quality assurance.

The objective should be continuity of information and clinical responsibility across the full episode of care. Patients should not have to trade timely treatment for uncertainty about who is responsible for their care.

The Committee should recommend nationally consistent principles for referral transparency and continuity, including timely referral-status information, indicative waiting periods, notification of rejected or redirected referrals, clear allocation of clinical responsibility and interoperable information-sharing across public and private settings. Implementation should preserve prioritisation according to clinical need and should be evaluated by whether it improves progression from referral to treatment, not merely referral processing.

# 3. AFFORDABILITY, OUT-OF-POCKET COSTS AND SPECIALIST FEES

Examine the affordability of specialist services, including out of pocket costs for consultations, diagnostics, procedures, and patient access to specialists through public health services, as well as factors influencing fee setting by specialists in the public and private health sectors.

## 3.1 SPECIALIST AFFORDABILITY IS A SIGNIFICANT CONCERN

Australians face substantial and increasing out-of-pocket costs for specialist care. The Department of Health, Disability and Ageing reports that Australians paid \$4.17 billion out of pocket for out-of-hospital specialist services in 2025, an increase of 75.8 per cent since 2019. Among patients who used an out-of-hospital specialist service and incurred a cost, the average annual out-of-pocket amount was approximately \$458.<sup>15</sup>

The Department also reports that the average out-of-pocket cost for an initial specialist consultation increased from \$94.72 in 2016 to \$158.75 in 2025 – an increase of 67 per cent, compared with headline CPI growth of 32 per cent over the same period. These figures demonstrate the need for practical reforms that reduce financial barriers to specialist care.<sup>16</sup>

The Department's consultation focuses principally on excessive fees, whereas this Inquiry has a broader remit encompassing workforce capacity, public hospital access, private health insurance and referral pathways. The ASA supports action on genuinely excessive charging but considers that it must form part of a wider response addressing the multiple factors that determine patients' final out-of-pocket costs.

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<sup>15</sup> Department of Health, Disability and Ageing, *Specialist Affordability*, p. 2.

<sup>16</sup> Ibid. 3.

### 3.2 EXCESSIVE CHARGING SHOULD BE ADDRESSED FAIRLY AND PROPORTIONATELY

The ASA supports ethical, reasonable and transparent fee setting and does not support excessive or egregious charging. The Department's analysis indicates that most specialists follow professional guidance concerning reasonable fees, while a small minority of services are charged substantially above the median for the same item.

The Department reported that, in 2025:

- 1.1 per cent of in-hospital specialist services were charged at between three and five times the median fee, and 0.7 per cent at more than five times the median; and
- 0.7 per cent of out-of-hospital specialist services were charged at between three and five times the median fee, and 0.1 per cent at more than five times the median.<sup>17</sup>

These data support targeted scrutiny of extreme outliers but do not establish that specialist fees generally are excessive. A statistical outlier may identify a service requiring further examination, but it does not, by itself, distinguish between clinically explainable variation, unusual billing circumstances, inadequate disclosure, an unreasonable fee or deliberately exploitative conduct.

Reform should therefore be specialty-specific, staged and proportionate. Governments should use accurate data, confidential provider feedback, education and peer-informed review to identify and address unreasonable charging, while retaining stronger investigation and enforcement measures for clearly egregious conduct.

### 3.3 ANAESTHESIA FEES REFLECT CLINICAL, FUNDING AND PATIENT FACTORS

The ASA's 2026 *Specialist Fees and Patient Out-of-Pocket Costs Survey* received 1,121 responses from specialist anaesthetists, representing approximately 24 per cent of anaesthetists working in private or mixed public–private practice. Conducted nationally in January and February 2026, the survey examined fee-setting practices, participation in private health insurer arrangements, informed financial consent and patient affordability.<sup>18</sup>

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<sup>17</sup> Ibid. 7.

<sup>18</sup> Australian Society of Anaesthetists, *Specialist Fees and Patient Out-of-Pocket Costs*, p. 3.

Respondents most commonly identified the following factors as influencing their fees:

- procedure duration – 60 per cent;
- procedure complexity – 55 per cent;
- private health insurer gap arrangements – 54 per cent;
- the ASA or AMA Relative Value Guide unit value – 53 per cent;
- minimising patient out-of-pocket costs – 44 per cent; and
- patient circumstances or ability to pay – 38 per cent.<sup>19</sup>

These findings indicate that anaesthesia fees cannot be assessed reliably against a single benchmark. They reflect the time and complexity of care, private health insurer rules, professional fee guidance and anaesthetists' consideration of patient affordability.

The survey also found that 84 per cent of respondents participated in private health insurer no-gap or known-gap arrangements, or a combination of both. Among participating anaesthetists, most private patients were billed under these arrangements, with known-gap billing applying to a larger share of patients than no-gap billing. This high level of participation demonstrates the significant influence of insurer benefit schedules and gap-scheme rules on both anaesthesia fees and patients' final out-of-pocket costs.<sup>20</sup>

### 3.4 ANAESTHESIA BILLING REQUIRES SPECIALTY-SPECIFIC ANALYSIS

Anaesthesia billing reflects the complete episode of care and cannot be assessed reliably by examining individual Medicare Benefits Schedule items in isolation. An anaesthesia account may include consultation, initiation, time, complexity and modifier items, as well as related services. The duration or complexity of care may also change after treatment has commenced.

The Department's recent consultation paper acknowledges that modifier items are commonly billed with anaesthesia services to account for factors such as procedure length and patient complexity.<sup>21</sup> It also notes that its analysis does not fully account for modifiers, the Multiple Operation Rule or deposits.<sup>22</sup> An apparent statistical outlier at the level of an individual item may therefore not represent an excessive total fee if the data do not capture the complete episode of care or the allocation of the patient's out-of-pocket cost across billed items.

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<sup>19</sup> Ibid. 7.

<sup>20</sup> Ibid. 8.

<sup>21</sup> Department of Health, Disability and Ageing, *Specialist Affordability*, p. 10.

<sup>22</sup> Ibid. 25.

Before applying regulatory thresholds to anaesthesia, the Department should undertake specialty-specific analysis in consultation with specialist anaesthetists. That analysis should consider:

- the structure of the MBS Anaesthesia Relative Value Guide;
- initiation, time and modifier items;
- consultation and other co-claimed services;
- patient and service complexity;
- changes in service mix;
- private health insurer benefits and gap arrangements;
- the allocation of out-of-pocket costs across the episode of care; and
- geographic and practice-cost differences.

The Department should also distinguish services delivered by specialist anaesthetists from other services included within the broader Anaesthetics category or billed using the same MBS items by other eligible practitioners.

The Committee should recommend that any definition of excessive charging, statistical threshold or regulatory response be tested against complete episode-level data and the billing structure of the relevant specialty. This would support action against genuinely unreasonable fees while reducing the risk that legitimate clinical and billing variation is incorrectly classified as excessive.

### **3.5 MBS AND HEALTH INSURER BENEFITS INFLUENCE PATIENT OUT-OF-POCKET COSTS**

A specialist's fee is only one component of a patient's out-of-pocket cost. For insured in-hospital treatment, the amount ultimately paid by the patient reflects the interaction between the specialist's fee, the Medicare benefit, the private health insurer benefit and the rules applying to any no-gap or known-gap arrangement. Affordability reform should therefore examine the adequacy and indexation of public and private benefits, rather than treating specialist fees as the sole determinant of patient costs.

### 3.5.1 THE ASA AND MBS RELATIVE VALUE GUIDES PERFORM DIFFERENT FUNCTIONS

The Relative Value Guide was developed to reflect the time and complexity of anaesthesia care more accurately than billing linked solely to surgical items. It was adopted by the ASA in 1970, incorporated into the AMA Fees List in 1989 and introduced into the Medicare Benefits Schedule in 2001.

The ASA RVG provides professional guidance to anaesthetists when determining fees. Its unit value is a professional fee benchmark that takes account of changes in clinical practice, professional costs and broader economic conditions. The MBS Anaesthesia RVG performs a different function: its unit value is a government-set rebate parameter used to calculate Medicare benefits for eligible anaesthesia services. The ASA and MBS unit values should therefore not be treated as equivalent measures.

The MBS Anaesthesia RVG also requires periodic modernisation to reflect contemporary clinical practice. The absence of initiation items for some procedures can complicate billing and informed financial consent where the necessary service is not adequately represented in the MBS. The ASA's current RVG review provides an opportunity to identify items that may require government review or updating.

### 3.5.2 THE RELATIVE VALUE OF MBS ANAESTHESIA BENEFITS HAS DECLINED

When the MBS Anaesthesia RVG was introduced in 2001, its unit value was \$17.15. By the end of 2025, it had increased to \$23.10 – an increase of 34.7 per cent. Over the same period, the ASA RVG unit value increased from \$50.50 to \$110.00. This comparison illustrates the different trajectories of a professional fee benchmark and a government rebate parameter; it should not be interpreted as a comparison between two measures designed to cover the same proportion of service cost.

Over the corresponding period from the December quarter 2001 to the December quarter 2025:

- headline CPI increased by 91.6 per cent;
- the ABS Health group increased by 189.7 per cent; and
- the ABS Medical and hospital services subgroup increased by 282.3 per cent.<sup>23</sup>

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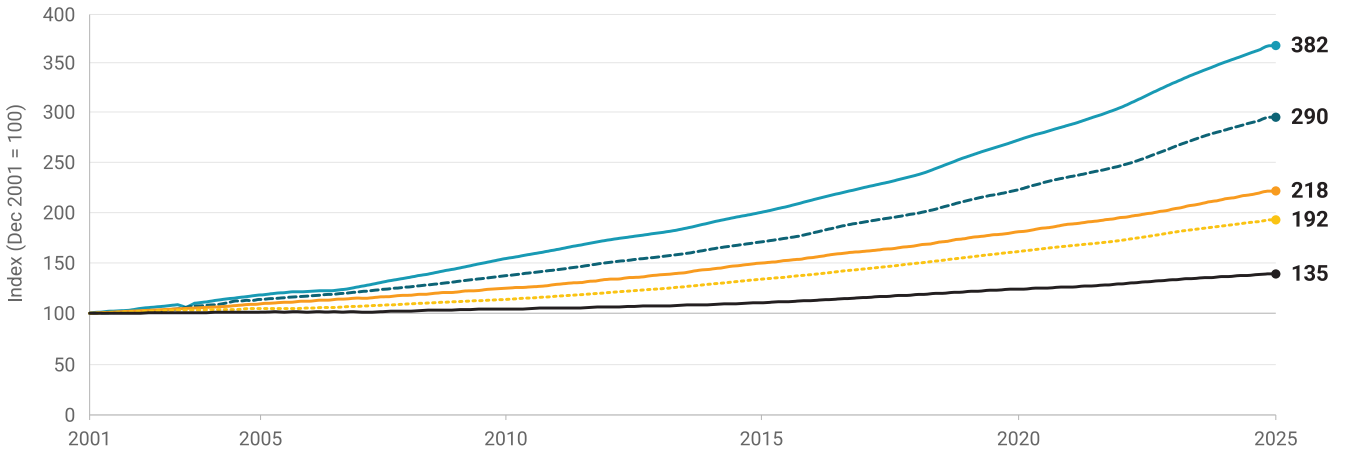
<sup>23</sup> Australian Bureau of Statistics, *Consumer Price Index*, Australia, cat no 6401.0, Table 18: 'CPI: Quarterly Group, Sub-group and Expenditure Class, Weighted Average of Eight Capital Cities' (Time Series Workbook, 2026) available at <https://www.abs.gov.au/statistics/economy/price-indexes-and-inflation/consumer-price-index-australia/aug-2026/6401018.xlsx>

# MBS anaesthesia rebates have not kept pace with inflation or health sector cost growth

Cumulative increase in key measures, December 2001 – December 2025

24 years of under-indexation has significantly eroded the value of MBS anaesthesia rebates.

Indexed growth (December 2001 = 100)



Total increase (December 2001 – December 2025)

|                                                                                                                                                                                              |                                                                                                                                                                       |                                                                                                                                                                                                         |                                                                                                                                                                                       |                                                                                                                                                                                    |
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| <div></div> <div><b>+282.3%</b></div> <div>Medical and hospital services CPI</div> <div>26.03 → 99.50</div> | <div></div> <div><b>+189.7%</b></div> <div>Health CPI</div> <div>34.36 → 99.54</div> | <div></div> <div><b>+117.8%</b></div> <div>ASA RVG unit value (anaesthetist costs)</div> <div>\$50.50 → \$110.00</div> | <div></div> <div><b>+91.6%</b></div> <div>Headline CPI (All groups)</div> <div>52.35 → 100.32</div> | <div></div> <div><b>+34.7%</b></div> <div>MBS RVG unit value</div> <div>\$17.15 → \$23.10</div> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Source:** Australian Bureau of Statistics, Consumer Price Index, Australia, December 2025, Table 18 – CPI: Quarterly Group, Sub-group and Expenditure Class, Weighted Average of Eight Capital Cities (All groups CPI, Health, and Medical and hospital services series).

ASA and MBS RVG unit values from ASA Relative Value Guide and MBS fee schedules (2001 and 2025).

**Calculations:** Cumulative percentage increase calculated as (End 2025 value ÷ End 2001 value – 1) × 100.

**ABS note:** The quarterly CPI series was re-referenced in 2025 (September 2025 = 100); this changes index levels but does not revise percentage movements.

The MBS RVG unit value therefore increased substantially more slowly than both general inflation and the cited health price indices. As an illustration, if the 2001 MBS RVG unit value had increased in line with headline CPI, it would have reached approximately \$32.87 by the December quarter 2025, compared with the actual value of \$23.10.

These CPI series measure changes in consumer prices rather than the direct input costs of an anaesthesia practice. They provide economic context for the movement of the MBS unit value over time but do not, by themselves, determine the appropriate fee or Medicare benefit for an anaesthesia service.

The divergence reflects, in part, periods in which MBS rebates were not indexed, including the general indexation freeze between November 2012 and July 2019, apart from limited indexation of attendance items. Although annual indexation has resumed and the MBS RVG unit value increased to \$23.70 from 1 July 2026, the longer-term comparison indicates that indexation has not preserved its relative value.

The Committee should recommend an independent review of the indexation methodology applying to MBS anaesthesia benefits. The review should consider the long-term movement in the MBS RVG unit value, changes in clinical practice and professional costs, and the interaction between Medicare and private health insurer benefits.

### **3.5.3 INSURER BENEFIT SCHEDULES AND GAP-SCHEME RULES CAN AMPLIFY PATIENT COSTS**

For insured in-hospital medical services, private health insurers are required to contribute towards eligible benefits in addition to Medicare. Insurers may also pay higher benefits where a practitioner participates in a no-gap or known-gap arrangement and complies with the insurer's scheme conditions.

Under a no-gap arrangement, the practitioner accepts the combined Medicare and insurer benefits as full payment and the patient incurs no out-of-pocket cost for the medical service. Under a known-gap arrangement, the practitioner may charge a disclosed patient gap up to the limit specified by the insurer.

Where a practitioner's fee exceeds the applicable known-gap limit, the service may cease to qualify for the insurer's higher benefit. The insurer payment may then revert to the statutory minimum. A relatively small increase above the cap can therefore produce a disproportionate increase in the patient's out-of-pocket cost.

Known-gap limits and insurer benefit schedules have generally not increased in line with changes in professional fees, Medicare benefits or broader prices. Most major Australian private health insurers cap the known gap at \$500 per episode of care, which have generally not increased over the last 25 years. Furthermore, some insurers have also moved from applying known-gap limits to individual items to applying a single limit across the complete episode of care. These arrangements can affect both the benefit paid by the insurer and the amount ultimately left for the patient.

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.

The ASA's 2026 Specialist Fees and Patient Out-of-Pocket Costs Survey found that 84 per cent of respondents participated in insurer no-gap or known-gap arrangements, or a combination of both. Four in five participating respondents reported that they always or sometimes accepted the insurer's known-gap benefit even where it was below their usual fee.<sup>24</sup> This indicates that many anaesthetists accept a lower fee to preserve patients' access to the higher insurer benefit.

Table 1 (below) compares selected fee and benefit parameters in 2024 and 2025. The amounts are not directly equivalent: the ASA amount is a professional fee benchmark, the MBS amount is a government rebate parameter, and the insurer amounts are benefits payable under specified products and scheme conditions. Nevertheless, the comparison demonstrates that insurer schedules, together with Medicare benefits and gap-scheme rules, materially influence the amount that must be absorbed by the practitioner or paid by the patient.

*Table 1: Selected ASA, MBS and private health insurer RVG unit values, 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             |
| <b>Known gap products</b> |                     |                     |
| 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             |
| <b>No gap products</b>    |                     |                     |
| HBF Full Cover            | \$35.85             | \$36.70             |
| HCF                       | \$38.35             | \$39.25             |
| Bupa                      | \$38.25             | \$39.15             |

<sup>24</sup> Australian Society of Anaesthetists, *Specialist Fees and Patient Out-of-Pocket Costs*, p. 5.

The Committee should recommend a coordinated review of private health insurer benefit schedules, known-gap limits and gap-scheme rules. The review should examine:

- whether insurer benefits and known-gap limits are subject to appropriate and transparent indexation;
- whether exceeding a gap limit causes a disproportionate reduction in the insurer benefit;
- whether episode-level caps appropriately reflect the structure of anaesthesia billing;
- how benefit schedules vary across products, hospitals and eligibility pathways; and
- how these arrangements affect patient out-of-pocket costs and practitioner participation.

Medicare and private health insurer benefits are integral to specialist affordability. Reform should assess how each component of the funding chain contributes to the patient's final out-of-pocket amount and ensure that changes do not simply transfer costs between patients, practitioners, insurers and the public hospital system.

### **3.6 BENEFIT SETTINGS CAN INFLUENCE SERVICE PARTICIPATION AND AVAILABILITY**

The adequacy of Medicare and private health insurer benefits is one factor that may influence patient out-of-pocket costs, participation in insurer arrangements, the hours specialists offer and the distribution of activity between public and private settings. Where benefits do not keep pace with relevant costs, practices may absorb a greater shortfall, patients may face higher gaps, or providers may alter their participation in particular funding arrangements.

These effects may be more significant in regional areas and services with limited workforce depth, where reduced participation cannot readily be replaced. They may also affect the availability of complex, high-acuity and after-hours services, for which workforce and service coverage are already constrained. If patients defer private treatment or seek care through the public system, demand may shift to already constrained public hospitals.

The Committee should recommend that any review of MBS benefits, private health insurer schedules, known-gap limits and scheme rules assess their effects on patient out-of-pocket costs, provider participation, regional service availability, complex and after-hours care, and demand transferred to public hospitals. Reform should be monitored to ensure that it improves affordability without reducing the specialist capacity available to patients.

### **3.7 TRANSPARENCY OF INSURER BENEFIT DIFFERENCES**

Some private health insurers offer higher medical benefits for eligible patients receiving specified procedures at participating hospitals. Under these arrangements, sometimes described as uplift arrangements, the insurer pays a higher benefit where the patient meets defined eligibility criteria, and the practitioner accepts the applicable fee schedule without charging the patient an out-of-pocket amount. These arrangements can improve affordability for patients who are eligible to use them.

Access to the higher benefit may, however, depend on factors including the procedure, the patient's clinical risk, the participating hospital, geographic location and the insurer's product or funding rules. Patients who require treatment at a fully resourced hospital because of clinical complexity, or who cannot reasonably access a participating facility, may receive a lower insurer benefit for the same or a comparable medical service. This can result in materially different out-of-pocket costs between members of the same fund.

While these arrangements can benefit individual patients, these differences raise legitimate equity and transparency concerns. The issue is not that insurers provide higher benefits through particular arrangements, but that patients may not be able to determine in advance why different benefits apply, whether they are eligible for the higher benefit, or how the choice of hospital or treatment pathway will affect their final cost. Patients with private health insurance should not be expected to understand these differences only after treatment has been arranged or an account has been issued.

Private health insurers should therefore be required to disclose, in plain language and before planned treatment:

- the medical benefit applicable to the patient;
- any no-gap, known-gap, uplift or preferred funding arrangement that may apply;
- the relevant clinical, product, hospital or geographic eligibility criteria;
- whether a materially different benefit would apply through another available treatment pathway; and
- the reason for any material difference in benefit for the same or a comparable service.

This disclosure should complement – not replace – practitioners' obligations to provide informed financial consent. Genuine fee transparency requires patients to receive information about both sides of the affordability equation: the amount charged by the practitioner and the benefits payable by Medicare and the insurer.

The Committee should recommend nationally consistent requirements for private health insurers to disclose material differences in medical benefits across products, hospitals and eligibility pathways. The Australian Government should also examine whether these arrangements create inequitable outcomes for patients who are excluded because of clinical risk, geographic location or lack of access to a participating facility.

## 4. IMPACT OF DELAYED SPECIALIST ACCESS

Examine the impact on patient outcomes by delays due to cost, distance and waiting times, and broader system impacts on primary care, emergency departments, public hospitals, chronic disease management, as well as impacts on people due to deferred or missed care.

### 4.1 COST, DISTANCE AND WAITING TIMES ARE DELAYING CARE

The Department of Health, Disability and Ageing cites the *2024–25 ABS Patient Experiences Survey*, which found that 8.6 per cent of Australians aged 15 years and over – more than 1.9 million people – delayed or did not see a specialist because of cost<sup>25</sup>. This provides direct evidence that affordability is already limiting access to specialist care.

Cost is not the only barrier. Access may also be delayed by specialist shortages, long public waiting times, limited outpatient and procedural capacity, elective surgery cancellations, distance from services and the additional travel and accommodation required to obtain care. These barriers can compound one another, particularly for patients in regional and remote communities.

Delayed specialist assessment or treatment may allow a condition to deteriorate, prolong pain or disability, delay a return to work or caring responsibilities, and increase the likelihood that a patient requires more intensive care. Although the consequences vary by condition and clinical urgency, timely access can reduce avoidable deterioration and support earlier, better-coordinated treatment.

### 4.2 THE FINANCIAL BURDEN ACCUMULATES ACROSS THE CARE PATHWAY

Patients commonly incur costs across an entire episode of care rather than through a single consultation. Depending on the condition and treatment pathway, costs may include specialist consultations, diagnostic services, procedural care, anaesthesia, follow-up appointments, medicines, travel, accommodation and time away from work or caring responsibilities.

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<sup>25</sup> Department of Health, Disability and Ageing, *Specialist Affordability*, p. 13.

The cumulative burden can be particularly significant for people with chronic or complex conditions, patients requiring repeated procedures or ongoing psychiatric care, and regional or remote patients who must travel to obtain treatment. Patients may also have limited practical ability to compare providers or change treating teams after care has commenced.

Affordability policy should therefore assess the total patient contribution across the care pathway, not only the fee for an initial consultation or an individual service. Better data are needed on cumulative out-of-pocket costs, including non-medical costs associated with travel and time away from work.

### **4.3 WORKFORCE AND SERVICE CAPACITY DETERMINE ACCESS TO TREATMENT**

An available specialist does not, by itself, provide access to treatment. For procedural care, access also depends on diagnostic services, operating theatres or procedure rooms, hospital beds, nursing and allied health staff, preoperative assessment, postoperative care and appropriate escalation arrangements.

The ASA's workforce modelling projects that demand for anaesthesia services will grow faster than workforce supply<sup>26</sup>. ASA member feedback also identifies constraints including limited public outpatient capacity, long surgical waits, elective surgery cancellations, regional workforce shortages and insufficient procedural capacity.

Governments should therefore measure access across the complete pathway—from referral and specialist assessment to diagnostics, preparation, treatment and follow-up. Workforce planning should be aligned with investment in the infrastructure and supporting teams needed to convert specialist expertise into patient care.

### **4.4 DELAYED CARE CREATES WIDER HEALTH-SYSTEM PRESSURES**

When patients cannot obtain timely specialist care, responsibility does not disappear. General practitioners may need to manage patients for longer while they wait, emergency departments may see patients whose conditions have deteriorated, and public hospitals may face demand that could have been addressed earlier or in another setting.

Public and private capacity are also interdependent. If patients cannot access or afford private treatment, some may defer care or seek treatment through already constrained public services. Conversely, where public capacity is insufficient, governments may commission care from private providers to reduce waiting lists.

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<sup>26</sup> Australian Society of Anaesthetists, *Anaesthetist Workforce Modelling Final Report*, p. 3.

Reforms affecting specialist fees, Medicare or insurer benefits should therefore be assessed for their effects on patient access, private-sector participation, public hospital demand, regional availability and complex or after-hours services. The objective should be to expand timely access rather than transfer patients, costs or pressure between sectors.

## 4.5 NATIONAL REFORM SHOULD FOCUS ON MEASURABLE PROGRESSION TO CARE

The 2026–31 National Health Reform Agreement and National Health Reform Strategy provide a framework for governments to address workforce shortages, fragmented care and inequitable access.<sup>27</sup> For specialist and procedural services, progress should be assessed by whether patients move safely and promptly through the full care pathway – not only by the number of referrals processed, but consultations also delivered or specialists registered.

The Committee should recommend nationally consistent reporting on:

- waiting times from referral to specialist assessment and from assessment to treatment;
- the number of patients whose care is delayed, deferred or cancelled;
- unmet need and variation by location, specialty and socioeconomic circumstances;
- cumulative medical and non-medical out-of-pocket costs;
- public and private service capacity; and
- the effect of reforms on primary care, emergency departments and public hospital demand.

Governments should use these data to target workforce and infrastructure investment, improve coordination across public and private services, and identify whether reforms are reducing delay without compromising clinical need, continuity of care or patient safety.

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<sup>27</sup> Health Ministers' Meeting, *2026–31 National Health Reform Strategy* (endorsed 4 September 2026).

# 5. INNOVATIVE AND EMERGING MODELS OF CARE



Assess innovative and emerging models of care that may improve access to medical specialists.

No single model will resolve specialist access problems across Australia. Models should be selected according to the barrier being addressed, the clinical needs of the population and the capacity of the local health system. Their purpose should be to extend access to safe specialist care – not simply to relocate responsibility or substitute one workforce constraint for another.

## 5.1 REGIONAL CLINICAL NETWORKS CAN EXTEND SPECIALIST EXPERTISE

Australia's geography means that not every community can sustainably support every specialist service locally. Regional clinical networks can combine locally delivered care with specialist outreach, advice, training and escalation support from larger centres.

Specialist anaesthetists and appropriately trained Rural Generalist or GP anaesthetists have complementary roles within these networks, according to clinical complexity, local service capability and credentialled scope of practice. Safe and sustainable models require:

- clearly defined scopes of practice;
- appropriate training, credentialling and maintenance of skills;
- access to continuing professional development and specialist support;
- shared clinical governance;
- reliable escalation, retrieval and transfer pathways; and
- clear criteria for care that can be delivered locally and care that requires transfer.

Governments should support regional networks that increase the range of care delivered safely close to home while maintaining timely access to specialist-led services for patients whose needs exceed local capability. Their performance should be assessed against patient access, transfers, cancellations, clinical outcomes, workforce retention and continuity of care.

## 5.2 FLEXIBLE WORKFORCE ARRANGEMENTS CAN RETAIN LOCAL SPECIALIST CAPACITY

Health services should use employment arrangements that reflect local workforce and service conditions. Staff Specialist, Visiting Medical Officer, part-time and mixed public–private arrangements can enable specialists already based in a community to contribute to public services and may reduce unnecessary reliance on short-term workforce solutions.

These arrangements should be designed around local demand, infrastructure, on-call requirements, training responsibilities and the need for a stable specialist presence. They should not create an unnecessary all-or-nothing choice between full-time salaried employment and private practice.

Governments and health services should identify where rigid employment arrangements are limiting participation and test more flexible models with clear expectations for availability, continuity, supervision, governance and accountability.

## 5.3 PRIVATE HOSPITAL CAPACITY CAN SUPPLEMENT CONSTRAINED PUBLIC SERVICES

Where appropriate capacity is available, governments may commission private hospitals and specialists to treat public patients or reduce defined waiting lists. These arrangements should supplement – not replace – sustained investment in public hospital capability and should allocate access according to clinical need.

Commissioned public–private pathways should specify:

- transparent patient-selection and prioritisation criteria;
- responsibility for pre-treatment assessment and optimisation;
- timely transfer of clinical information and access to records;
- responsibility for postoperative care and complications;
- escalation and transfer arrangements;
- implications for specialist training;
- funding, reporting and accountability requirements; and
- outcome measures covering the complete episode of care.

Such arrangements should be time-limited or periodically reviewed where appropriate. Evaluation should examine whether they reduce waiting times and improve treatment completion without weakening public capacity, fragmenting care or creating inequitable access.

## 5.4 DIGITAL AND SHARED-CARE MODELS CAN REDUCE DISTANCE BARRIERS

Virtual specialist care, shared-care arrangements and hub-and-spoke models can reduce avoidable travel and extend specialist expertise to regional and remote services. Appropriate uses may include selected consultations, preoperative assessment and optimisation, multidisciplinary case conferencing, follow-up care and clinical support for locally based practitioners.

Digital care should be used only where it is clinically appropriate and should not replace in-person assessment, monitoring or treatment where these are required. Models should provide:

- continuity of information and responsibility;
- secure and interoperable information sharing;
- clear escalation and referral pathways;
- access to in-person care when needed; and
- patient support for connectivity, digital literacy, disability, language or privacy barriers.

Evaluation should consider whether digital models reduce travel, waiting times and missed appointments while maintaining clinical outcomes, patient experience and equitable access.

## 5.5 NEW MODELS SHOULD BE EVIDENCE-BASED AND SAFELY GOVERNED

The ASA supports multidisciplinary and innovative models that improve access, use specialist expertise effectively and maintain high standards of care. Workforce shortages alone, however, should not justify transferring specialist medical responsibility to practitioners without the training, authority, supervision or accountability required for that responsibility.

Before wider implementation, new models should be tested through properly governed pilots or staged implementation. Evaluation should address:

- patient safety and clinical outcomes;
- access, waiting times and treatment completion;
- equity, including regional and socioeconomic effects;
- continuity and patient experience;
- workforce sustainability and retention;
- effects on specialist training;
- cost-effectiveness and system capacity; and
- any transfer of costs, risks or workload between sectors or practitioners.

The Committee should recommend a nationally consistent evaluation framework for emerging specialist-care models. Governments should expand models that demonstrably improve access and outcomes, modify those that create avoidable risks or inequities, and discontinue those that do not provide measurable benefit.

## 6. RECOMMENDATIONS

The Australian Society of Anaesthetists recommends a coordinated reform program addressing specialist access and affordability across the full care pathway. Reform should align workforce planning, training, service capacity, referral pathways, Medicare and private health insurance settings, patient information and regulatory responses.

The recommendations below should be implemented as a connected package. Measures directed at one part of the system should be assessed for their effects on patient access, provider participation, regional services, public hospital demand and the sustainability of specialist care.

### **RECOMMENDATION 1: DEVELOP AND FUND A NATIONALLY COORDINATED SPECIALIST WORKFORCE STRATEGY**

The Australian Government and state and territory governments should develop a nationally coordinated specialist workforce strategy based on projected demand and effective specialist capacity, rather than specialist headcount alone.

The strategy should:

- account for full-time-equivalent participation, hours worked, retirement and workforce exits, geographic distribution, service availability and the time required to train specialists;
- fund at least 50 additional anaesthesia trainees each year, with one-third undertaking training in regional and rural Australia;
- provide sufficient specialist supervision, appropriate case volume and complexity, required subspecialty experience, accredited training environments and hospital capacity;
- establish sustainable regional training networks and coordinated recruitment and retention measures;
- support appropriate working conditions, leave and backfill arrangements, continuing professional development, clinical networks and specialist backup in regional services; and
- enable flexible Staff Specialist, Visiting Medical Officer, part-time and mixed public–private arrangements where these would retain locally available specialist capacity.

Workforce planning should be aligned with investment in the clinics, theatres, beds, diagnostic services, nursing and allied health teams needed to convert specialist expertise into patient care.

## **RECOMMENDATION 2: ESTABLISH NATIONALLY CONSISTENT REQUIREMENTS FOR REFERRAL TRANSPARENCY AND CONTINUITY OF CARE**

The Australian Government and state and territory governments should establish nationally consistent principles for specialist referral transparency, supported by interoperable referral and information-sharing systems.

Patients and referring practitioners should receive:

- timely confirmation that a referral has been received;
- the referral's triage status;
- an indicative waiting period;
- the next expected step;
- notification if a referral is rejected, redirected or cannot progress without further information; and
- information about clinically appropriate alternatives, where available.

Waiting-period information should be identified as indicative and should not displace prioritisation according to clinical need.

Where patients move between providers or public and private settings, referral pathways should clearly allocate responsibility for pre-treatment assessment, transfer of clinical information, access to records, treatment, postoperative care, escalation and quality assurance. Reform should be evaluated according to whether it improves progression from referral to treatment, not merely the processing of referrals.

## **RECOMMENDATION 3: COMMISSION AN INDEPENDENT REVIEW OF MEDICARE AND PRIVATE HEALTH INSURER BENEFIT SETTINGS**

The Australian Government should commission an independent review of the adequacy, design and indexation of:

- MBS anaesthesia benefits;
- private health insurer benefit schedules;
- no-gap and known-gap arrangements;
- known-gap limits;
- episode-level caps; and
- other insurer scheme rules affecting medical benefits.

The review should consider:

- the long-term change in the relative value of MBS anaesthesia benefits;
- changes in clinical practice and professional costs;
- the interaction between Medicare and insurer benefits;
- whether insurer benefits and known-gap limits are subject to appropriate and transparent indexation;
- whether exceeding a known-gap limit causes a disproportionate reduction in the insurer benefit;
- whether episode-level caps appropriately reflect the structure of anaesthesia billing;
- variation across insurer products, hospitals and eligibility pathways; and
- effects on patient out-of-pocket costs, provider participation, regional availability, complex and after-hours care, and public hospital demand.

The review should distinguish clearly between a professional fee benchmark, a government rebate parameter and a private health insurer benefit. Its objective should be to improve affordability without merely transferring costs between patients, practitioners, insurers and public hospitals.

## **RECOMMENDATION 4: REQUIRE INTEGRATED FINANCIAL TRANSPARENCY BEFORE PLANNED CARE**

The Australian Government should establish nationally consistent financial-transparency requirements for planned specialist care, with distinct and complementary obligations for providers and private health insurers.

Where practicable, patients should receive clear and appropriately contextualised information about:

- the provider's proposed fee;
- the applicable Medicare benefit;
- the applicable private health insurer benefit;
- any no-gap, known-gap, uplift or preferred funding arrangement;
- relevant clinical, product, hospital or geographic eligibility criteria;
- the likely out-of-pocket cost; and
- whether a materially different benefit may apply through another available treatment pathway.

Private health insurers should explain the reason for any material difference in benefits for the same or a comparable service across products, hospitals or eligibility pathways. The Australian Government should also examine whether these differences create inequitable outcomes for patients who are excluded because of clinical risk, geographic location or lack of access to a participating facility.

Transparency requirements should recognise the practical constraints of emergency, urgent and otherwise unplanned care. Price information should also be presented in a way that does not imply that a higher fee necessarily indicates higher clinical quality.

## **RECOMMENDATION 5: ESTABLISH A SPECIALTY-SPECIFIC, STAGED AND PROPORTIONATE FRAMEWORK FOR EXCESSIVE CHARGING**

Any regulatory framework established to identify and address genuinely excessive or egregious charging should not treat such conduct as representative of specialist fees generally.

Any such framework should:

- use complete episode-level data and specialty-specific analysis;
- account for the relevant MBS structure, time requirements, modifier items, co-claimed services, clinical complexity, service mix and insurer arrangements;
- distinguish statistical outliers from clinically explainable variation, unusual billing circumstances, inadequate disclosure, unreasonable fees and deliberately exploitative conduct;
- use confidential provider feedback, education, peer-informed review and remediation as initial responses where appropriate;
- retain investigation and enforcement for clearly egregious conduct;
- protect a patient's Medicare benefit from withdrawal because of a provider's conduct;
- provide appropriate mechanisms for patient remediation; and
- monitor effects on Medicare participation, price convergence, cost-shifting, regional access, complex care and public hospital demand.

For anaesthesia, any statistical threshold or regulatory response should be tested against the complete episode of care and developed in consultation with specialist anaesthetists.

## **RECOMMENDATION 6: ALIGN SERVICE-CAPACITY INVESTMENT, EMERGING MODELS OF CARE AND NATIONAL DATA**

Governments should align workforce investment with the service capacity required to provide care and should support evidence-based models that improve access without weakening clinical governance, continuity, training or public-sector capability.

This should include:

- investment in outpatient services, diagnostics, procedure rooms, operating theatres, beds and supporting clinical teams;
- regional clinical networks combining locally delivered care with specialist outreach, advice, training and escalation support;
- appropriately governed flexible workforce and employment models;
- commissioned use of private hospital capacity where it supplements, rather than replaces, sustained investment in public services;
- clinically appropriate digital, shared-care and hub-and-spoke models that reduce avoidable travel and improve access to specialist expertise; and
- reliable escalation, retrieval and transfer pathways for care that cannot safely be delivered locally.

The Australian Government should establish a nationally consistent framework for piloting and evaluating emerging specialist-care models. Evaluation should assess:

- patient safety and clinical outcomes;
- access, waiting times and treatment completion;
- regional and socioeconomic equity;
- continuity and patient experience;
- workforce sustainability and retention;
- effects on specialist training;
- cost-effectiveness and system capacity; and
- any transfer of costs, risks or workload between sectors or practitioners.

Governments should also improve national reporting on:

- waiting times from referral to specialist assessment and from assessment to treatment;
- delayed, deferred and cancelled care;
- unmet need by location, specialty and socioeconomic circumstances;
- cumulative medical and non-medical patient costs;
- effective specialist capacity;
- public and private service capacity;
- provider fees and Medicare and insurer benefits; and
- effects on primary care, emergency departments and public hospital demand.

Governments should expand models that demonstrably improve access and outcomes, modify those that create avoidable risks or inequities, and discontinue those that do not provide measurable benefit.

# CONCLUSION

Taken together, these recommendations provide a practical framework for improving access and affordability without reducing the policy task to a narrow debate about specialist fees. The test of reform should be whether patients can progress safely and promptly from referral to treatment at a cost they can afford.

Achieving that outcome requires shared responsibility across the Australian Government, state and territory governments, health services, private health insurers, hospitals and the medical profession. Reform should expand effective specialist capacity, ensure that Medicare and insurer benefits provide meaningful support, strengthen patient information and continuity, invest in the service capacity needed to deliver care, evaluate emerging models against measurable outcomes, and address genuinely excessive conduct proportionately.

The ASA thanks the Committee for the opportunity to make this submission and would welcome the opportunity to discuss its recommendations.

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