

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

House Standing Committee on Health, Aged Care and Disability
April 2026

Focus of This Submission

This submission addresses the persistent failure of successive Australian governments to adequately index Medicare Benefits Schedule (MBS) rebates for specialist medical services. The resulting gap between stagnant rebates and the rising real cost of specialist care has become the single greatest structural driver of unaffordable out-of-pocket costs for Australian patients. Until this foundational failure is corrected, no other reform to specialist access or affordability can succeed.

1. Introduction and Summary of Concern

Medicare was established on a principle of universality: that no Australian should be prevented from accessing necessary medical care by financial hardship. For specialist services, this principle is now failing in plain sight. The mechanism of failure is straightforward — the government has persistently declined to index MBS rebates for specialist services in a manner that keeps pace with the actual cost of delivering care. The consequence is a structural and growing gap between what Medicare pays and what specialists must charge to sustain viable practices.

The result falls entirely on patients. Since 2010-11, the average out-of-pocket (OOP) gap payment for specialist attendances has risen from \$49.56 to \$117.18 in 2023-24 — a 136% increase — over a period in which the Consumer Price Index (CPI) rose by only 40% (Medical Journal of Australia, November 2025). This is not a minor rounding error in health policy. It represents a fundamental breach of the Medicare compact.

2. The History of MBS Rebate Inadequacy

2.1 The Indexation Freeze (2014–2020)

The most acute episode in this long-running failure was the MBS rebate freeze introduced by the Abbott Government in 2014. Framed as a budget savings measure, the freeze halted all routine indexation of MBS fees. Initially legislated to last four years, it was extended in 2016 through to 2020 — a six-year period during which providers received the same nominal dollar rebate regardless of rising wages, rent, equipment, and insurance costs.

The accumulated savings to government from this policy were estimated at \$2.8 billion. Those savings did not disappear — they were transferred directly to patients in the form of higher out-of-pocket costs. Research published in *Social Science & Medicine* confirmed that the freeze caused a widening of the gap between provider fees and Medicare benefits, with OOP costs rising for cancer patients and others with high service utilisation from 2015 onward.

2.2 Indexation Restored — But Inadequately

From 2017, indexation was phased back in: GP bulk-billing incentives from July 2017, standard GP and specialist consultation items from July 2018, and specialist procedures and allied health from July 2019. This was presented as a resolution to the crisis. It was not.

Indexation was restored at rates that bore no meaningful relationship to the genuine cost pressures facing specialist practices. The AMA's annual 'Gaps Poster' documented that despite average CPI growth of approximately 3% per year, MBS fees had only increased between 1.2% and 2.5% for most items between 1995 and 2012 — before the freeze even began. The freeze compounded decades of pre-existing under-indexation.

Key Finding: Grattan Institute (June 2025)

The Grattan Institute's landmark report 'Special Treatment: Improving Australians' Access to Specialist Care' found that even after indexation was restored, the average out-of-pocket cost per specialist service continued rising. As a rough estimate, had benefits been properly indexed to the Wage Cost Index 6 across the freeze period, the average benefit per service would have been \$4.40 higher (in 2025 dollars) in 2017-18 than in 2012-13. But the actual average out-of-pocket cost per service increased by \$9.60 over the same period — and has continued rising since.

3. The Quantified Impact on Patients

3.1 Out-of-Pocket Costs Have Reached Crisis Levels

The following data illustrates the extent to which patients are now bearing costs that should, under any fair reading of the Medicare compact, be substantially offset by public subsidy:

Metric	Figure	Source
Average OOP gap — specialist attendance (2010-11)	\$49.56	MJA, Nov 2025
Average OOP gap — specialist attendance (2023-24)	\$117.18	MJA, Nov 2025

Percentage increase in specialist OOP costs (2010-2024)	136%	MJA, Nov 2025
CPI increase over same period	~40%	ATO / MJA, Nov 2025
Average known-gap rise (private health, 5 years)	\$99 → \$135	Money.com.au, 2026
Average unknown-gap rise (private health, 5 years)	\$418 → \$685	Money.com.au, 2026
Gap payments rising vs. hospital costs	3x faster	Money.com.au, 2026
Specialist OOP costs — psychiatry (extreme-fee providers)	>\$650 avg.	Grattan Institute, 2025
Australians delaying/forgoing specialist care due to cost	~1.3 million	AIHW, 2016-17

3.2 The Bulk Billing Picture for Specialists

Unlike general practice, where bulk billing rates — though declining — remain the dominant mode of service, specialist bulk billing has never been widespread. The Grattan Institute found that the average person who saw a specialist in 2023 had only one-third of their appointments bulk billed. Even among low-income households, 72% of people who saw a private specialist paid a bill at least once.

This means the MBS rebate is the primary financial protection for the majority of Australians who see a private specialist. When that rebate is chronically inadequate, there is no safety net beneath it for most patients.

3.3 Equity Consequences

The burden of inadequate MBS rebates does not fall evenly. It falls hardest on those least able to bear it. Research consistently shows that:

- Patients in regional and remote areas pay higher out-of-pocket costs than metropolitan patients, due to lower specialist density and reduced competition.
- Patients with chronic or complex conditions — those who require the most frequent specialist contact — accumulate the largest annual OOP burdens.
- Low-income Australians face a choice between financial hardship and forgoing care; the public system waitlist is frequently the only alternative, with waits that can stretch to years.
- Patients in certain specialties — including psychiatry, endocrinology, cardiology, and ophthalmology — face particularly extreme OOP costs, with some extreme-fee providers charging more than double or triple the Medicare schedule fee.

4. Why Rebate Inadequacy Is the Root Cause

4.1 Specialists Are Not Simply Charging Whatever They Like

A common mischaracterisation of the out-of-pocket cost problem blames specialist greed. The evidence does not support this as a complete explanation. The Australian Society of Anaesthetists' landmark survey of over 1,100 anaesthetists, conducted in late 2025 and early 2026, found that on average, specialists are charging almost 30% less per unit than their preferred rate — indicating widespread self-restraint driven by a desire to minimise patient costs.

The same survey found that 72% of anaesthetists had received requests to reduce fees in the past year, and many routinely waive fees in emergency or hardship situations. The survey concluded explicitly that out-of-pocket costs are 'largely driven by stagnant MBS and private health insurance rebates, rather than excessive charges.'

The anaesthetists surveyed identified the single most impactful reform for reducing patient costs: 'Fixing MBS and private health insurance rebate indexation.'

4.2 Practice Costs Have Risen Substantially

Running a specialist medical practice in 2026 costs dramatically more than it did in 2014, let alone when many current MBS schedule fees were originally set. Specialists face rising costs in:

- Clinical staff wages (indexed to Award wage increases and market rates)
- Medical indemnity insurance (which has increased substantially for many specialties)
- Medical equipment, consumables, and technology
- Rent and facilities for private consulting rooms
- Administrative and compliance costs, including practice software and accreditation

When MBS rebates do not rise commensurately with these input costs, specialists face a binary choice: absorb the cost reduction (reducing income year on year in real terms) or pass it on to patients via higher fees. Many do both. The systemic result, across thousands of specialists over years and decades, is the persistent gap inflation we observe in the data.

4.3 The Indexation Formula Itself Is Inadequate

Even where indexation has been restored, the formula used — typically anchored to an amalgam of wage cost and CPI measures — has consistently undershot the genuine cost of delivering specialist medical care. Medical practice cost inflation differs from general CPI. It is driven by healthcare-specific wage growth, medico-legal costs, and the increasing technical complexity and capital intensity of modern specialist care.

A rebate indexation mechanism that is not designed to reflect the actual costs of specialist practice will, over time, guarantee that MBS rebates fall further and further below the cost of care — regardless of whether a formal freeze is in place.

5. The Two-Tiered System That Is Emerging

The consequence of decades of inadequate MBS indexation is the gradual emergence of a two-tiered healthcare system that is antithetical to Medicare's founding purpose:

- Those who can pay — whether directly or through premium private health insurance — access specialist care in acceptable timeframes and, increasingly, accept significant out-of-pocket costs as a cost of participation.
- Those who cannot pay face the public system, where waiting lists for many specialties extend to months or years. The Grattan Institute documented, for example, that one in ten people waiting for a respiratory/cystic fibrosis appointment in Sydney wait more than three years.

This is not a theoretical risk. It is the observable present state of the Australian specialist care system. It will worsen as long as the structural driver — inadequate MBS rebates — is left unaddressed.

6. Recommendations

This submission urges the Committee to make the following findings and recommendations:

Recommendation 1: Reform the indexation mechanism for specialist MBS rebates

The existing indexation formula should be replaced with one specifically calibrated to the cost inputs of specialist medical practice. This should include consideration of award wage growth in the health sector, medical indemnity costs, and capital equipment costs, in addition to CPI.

Recommendation 2: Implement a staged catch-up for the deficit accumulated since 2012

The cumulative under-indexation of specialist MBS rebates since 2012 represents a substantial structural deficit. A one-time, staged catch-up adjustment — phased over three to five years — should be developed and budgeted for, to partially restore the real value of rebates that has been eroded over the past decade.

Recommendation 3: Commit to annual, transparent, and adequate indexation

Annual indexation of MBS specialist rebates should be legislated as a standing commitment, with the rate published in advance and subject to parliamentary scrutiny. Future freezes or

deferrals should require explicit legislative approval and be accompanied by a patient impact statement.

7. Conclusion

The affordability crisis in specialist care in Australia has many dimensions, but a single, dominant structural cause: the failure of government to ensure that MBS rebates keep pace with the real cost of delivering specialist medical services. The evidence is unambiguous — out-of-pocket costs have risen at more than three times the rate of inflation over the past decade, patients are delaying and forgoing care, and the equity implications are severe.

The Committee has an opportunity to name this clearly. The solution is not complex: adequately index MBS rebates, restore the real value eroded since 2012, and commit to a transparent, formula-based mechanism that prevents this from happening again. Every other reform to specialist access — workforce, telehealth, referral pathways, public clinic capacity — will be undermined if the foundational problem of MBS rebate inadequacy is not addressed.

Medicare's promise to Australians was not a promise of heavily discounted specialist care with a large and growing patient co-payment. It was a promise of affordable, universal access. The government has the power — and the obligation — to restore that promise.

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