



THE AUSTRALASIAN COLLEGE
OF DERMATOLOGISTS

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**Submission to Senate Community Affairs
Legislation Committee**

**Health Legislation Amendment (Improving
Choice and Transparency for Private Health
Consumers) Bill 2026**

March 2026

To: Committee Secretary
Senate Community Affairs Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

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ABOUT THE ACD

The Australasian College of Dermatologists (ACD) is Australia's accredited training body and peak professional and membership organisation for medical specialists in dermatology. We represent 686 dermatologists Fellows (FACD) and 136 trainees. The ACD sets the clinical standard in dermatology and advocates for safe, evidence-based care.

Our vision is for the highest standard of skin health and dermatology care to be accessible to all patients and communities.

RESPONSE

Introduction

The Australasian College of Dermatologists welcomes the opportunity to make a submission on the Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026 (the Bill), with particular reference to the key measure *Transparency by Default*.

We understand that this measure proposes amendments to the Health Insurance Act 1973 (HI Act) and Private Health Insurance Act 2007 (PHI Act) to allow the Department of Health, Disability and Ageing (the Department) to publish information for consumers on medical fees charged by medical practitioners - including specialists and general practitioners - and likely out-of-pocket costs for their private healthcare experience. The stated purpose is to improve transparency in healthcare pricing so consumers can make informed decisions about their healthcare and obtain better value from private health insurance.

This submission focuses on the new Part VE of the HI Act.

Our position in brief:

- **ACD supports the Bill's transparency intent:** Australians deserve clear, reliable information on fees, rebates and likely out-of-pocket costs.
- **The single fee figure proposed in the Bill risks a number of unintended consequences. It must be accurate and contextualised** to be meaningful and safe for patients.
- **Transparency alone will not fix access or affordability.** Underinvestment in public dermatology and inadequate MBS rebates are driving delays, cost pressures and workforce constraints.
- **We seek to partner with Government and stakeholders** to codesign implementation that helps patients make informed choices and improves access to timely, appropriate dermatology care.

We support transparency that patients can trust. With accurate data, clear explanations and proper safeguards, transparency will help Australians make informed choices, while parallel investments in public services and fair rebates will ensure those choices lead to quality and safe healthcare.

Our Position

The ACD supports the Bill's intent

The ACD supports the Bill's intent to strengthen consumer access to clear, reliable information on medical fees and insurance coverage. All Australians have the right to transparent and timely

information on fees, Medicare rebates and private health insurance cover so they can make informed decisions in choosing their healthcare providers.

The ACD stands firmly with the specialist medical profession in our joint commitment to ethical billing. Patient interests must come first; fees must be fair, transparent and never exploitative. While specialist medical colleges do not set or regulate fees, these expectations of ethical, transparent and patient-centred practice are embedded across specialist medical college codes of conduct and professional guidance and are consolidated in the Council of Presidents of Medical Colleges (CPMC) *Medical Specialist Professionalism Framework: Ethical Billing and Fee Transparency*¹. Furthermore, ACD has long endorsed the *AMA's Guide to Informed Financial Consent*² – a document that empowers patients to discuss costs with their doctor.

Given this, we have concerns about mischaracterisation of the current level of cost transparency provided to patients in relation to specialist consultations in the Explanatory Memorandum to this Bill, which we would like to draw to the Committee's attention. The document asserts that 'consumers do not know the cost of specialist treatment, until they have paid for an appointment with a specialist to tell them this cost' and 'other information (such as medical costs) is available only after a consumer has paid a doctor for an appointment'.

These statements do not reflect standard practice and are incorrect. In practice, patients are advised of the known consultation fee at the time they first contact a clinic to make a booking—before the appointment is confirmed, any payment is made and the appointment attended. Statements such as these are unhelpful and misrepresentative.

Specialists overwhelmingly practise ethically, transparently and with deep commitment to patient care. Their setting and communicating of professional fees are compassionate, responsive to financial hardship and firmly grounded in informed financial consent. In dermatology, our member survey data reflects this clearly, with more than 90% of respondents offering bulk-billing according to patient need. Furthermore, concessions are common: more than 85% offer reduced fees for pensioners/concession card holders, for patients on low incomes, unemployed or facing financial hardship and for those experiencing social disadvantage or vulnerability; and 78% for people with chronic or complex disease requiring frequent follow-up.

The single fee figure proposed in the Bill risks a number of unintended consequences. It must be accurate and contextualised to be meaningful and safe for patients.

Transparency is only meaningful and safe for patients when it is accurate, contextualised and patient-centred.

The ACD supports transparency, including measures that help patients make informed decisions, but has concerns about how the current proposed legislation would be implemented in the absence of a defined methodology. The usefulness of proposed enhancements to Medical Costs Finder (MCF) will depend on the accuracy, completeness and clarity of the underlying data, including clinical context.

¹ Council of Presidents of Medical Colleges. (2026). *Medical specialist professionalism framework: Ethical billing and fee transparency*. <https://cpmc.edu.au/wp-content/uploads/2017/01/CPMC-Framework-Ethical-Billing-and-Fee-Transparency-032026.pdf>. Available at <https://cpmc.edu.au/statements>

² *AMA Guide to Informed Financial Consent* 2024 Update. Available at https://www.ama.com.au/articles/AMA_Informed_Financial_Consent_Guide_2024

As in the Explanatory Memorandum, ‘the department is developing an analytical approach for the derivation of a single fee figure that can be published for a medical practitioner’s provision of a service for a given financial year’. The intent for this figure to be developed, tested and published on the MCF at the end of 2026 or early 2027, as stated in the Explanatory Memorandum, is ambitious and we have concerns around output robustness within that timeframe.

Further, we consider a single fee figure approach to be a significant oversimplification of how health care is delivered from the consumer perspective. It risks misrepresenting complex care, generating misleading comparisons between specialists and distorting market behaviour.

While it is noted that the information published on the MCF ‘can only provide an *indication* of medical practitioner fees’ and cannot substitute for an individualised quote, it also concedes that the information published may ‘influence a consumer’s decision about their provider.’

This highlights several risks around the single fee figure approach. De-contextualised fee comparisons may inadvertently penalise practitioners providing complex care or deter them from treating high-need patients. Given health system literacy amongst consumers varies widely and that ‘episodes of care’ are rarely simple, some may mistakenly interpret information on the MCF as a quote and/or underestimate their true healthcare needs, compounding confusion and dissatisfaction if actual costs differ, eroding practitioner and health system trust.

Transparency can be a lever to address egregious billing. While a reduction in patient demand for practitioners charging extremely high fees relative to others is one possible outcome, the opposite effect is equally plausible, with patients equating higher prices with higher quality.

At a system-wide level, if poorly designed or implemented, these and other measures currently being discussed in public discourse risk driving unintended consequences such as practitioner withdrawal from MBS participation altogether and fuelling a private, rebate-free sector, with flow on impacts to private health insurance and the social compact that underpins the compulsory Medicare levy.³

Finally, Subsections 124ZY(3) to (6) provide for the Minister to make a legislative instrument specifying additional information that may be published, with the example of ‘if a national dataset relating to quality indicators of medical practitioners became established later’. These powers are broad and there is no process outlined for selection and validation of any future datasets nor how it is proposed these be linked with the cost of a billable service by an individual practitioner. Without robust safeguards, there is a significant risk that clinical quality indicators could be used prematurely or inappropriately, leading to misleading conclusions and unintended harm.

Transparency alone will not fix access or affordability

The ACD supports improved transparency and informed decision-making for patients, however transparency alone does not address the systemic drivers that limit Australians access to timely, affordable, high-quality and clinically appropriate care.

³ Faux M and Topperwien B, ‘The Commonwealth’s Power to Regulate Medical Fees: Constitutional Limits and Contemporary Pressures’ (Blog Post, *Australian Public Law*, 11 March 2026)
<<https://www.auspublaw.org/home/2026/3/the-commonwealths-power-to-regulate-medical-fees-constitutional-limits-and-contemporary-pressures-czwyb>>

The access implications are clearly recognised in the Explanatory Memorandum, which notes ‘Patients’ conditions can deteriorate while they linger on waiting lists. Long waits or missed care can delay vital diagnoses and treatment, and waiting for treatment or missing care can mean enduring pain and distress’. It further notes that ‘some communities receive less specialist care than others’ underscoring the uneven distribution of access across Australia.

Systemic drivers across the health system for dermatology include:

- Long-standing, multi-jurisdictional underinvestment in public dermatology services and training has led to limited outpatient capacity, meaning many patients cannot access the care they need through the public system.
- Constrained public capacity reduces training supervisory capacity and training places, directly constraining workforce supply and compounding access pressures over time.
- MBS rebates for specialist dermatology consultations are inadequate and are not equitable to consultation rebates for other specialist groups such as physicians and psychiatrists. Current rebates – \$86.15 for an initial attendance (MBS item 104) and \$43.35 for subsequent attendances (MBS item 105) - are almost half that of physician rebates and do not reflect the complex, time-intensive and ongoing nature of chronic skin disease diagnosis and management.
- Public discussion around “extreme billing” has been shaped by the Grattan Institute’s *Special treatment: Improving Australians’ access to specialist care* (2025). While the report has helped focus attention on affordability which we welcome, using a uniform “three times the Medicare rebate” threshold as a proxy for “extreme fees” assumes an equal baseline across specialties when this is not the case.

Fee setting in this context reflects unavoidable cost pressures. A survey of our members showed that among practice owners, the most influential factor in fee setting is overheads and cost of business, with reported five year increases highest for staff wages and payroll tax (cited by 99% of respondents), IT/digital/cyber security and compliance (82% of respondents), and medical equipment and consumables (81% of respondents). Notwithstanding these pressures, 98% of practice owners report their fees have increased less than or in line with rising costs, demonstrating sustained efforts to maintain affordability. The MBS Schedule fee is widely regarded as minimally relevant to fee setting because it is so far removed from the true cost of delivering care.

To address geographic access barriers, rural outreach is undertaken and often sustained at clinicians’ own expense, with dermatologists providing rural outreach reporting that less than half of service costs (43%) and travel costs (46%) are government-funded, with the remainder self-funded by dermatologists themselves.

The private sector’s response has been necessary to ensure that care can still be delivered in the absence of adequate public funding. Dermatologists are creating capacity, trying to maintain affordability amid rising costs, and sustaining outreach to underserved communities, but these efforts cannot substitute for long-term public investment in outpatient dermatology services and training.

Partnerships are crucial to improving access, transparency and affordability

The ACD recognises community concern about the affordability of healthcare, including specialist fees, particularly in the current cost of living environment. Ensuring dermatology care is financially accessible at the point of care is essential to improving patient outcomes and reducing downstream health system expenditure.

The ACD, alongside all 16 specialist medical colleges stands ready to partner with the Government to ensure the MCF is genuinely useful and safe for patients. Transparency measures will only achieve their intended purpose if they are developed and implemented in close collaboration with the medical profession and with consumers.

If the Bill is passed, we request that the Department of Health, Disability and Ageing collaborates closely with specialist medical colleges through the CPMC, and with consumer representatives. This collaboration is necessary to ensure data quality, contextual accuracy and presentation that genuinely supports patient understanding and informed choice. Robust safeguards must be built in to avoid unintended consequences such as de-contextualised fee comparisons that inadvertently penalise complex care or deter care for high-need patients.

The ACD is committed to constructive partnership with Government to co-design implementation that helps patients make informed choices and on solutions to improve access to timely, appropriate specialist dermatology care. This includes practical collaboration on MCF data standards and presentation, and joint work to address the underlying system settings that drive cost and access barriers.

Australia has one of the best performing health systems in the world, underpinned by two core strengths: the high standard of our health practitioners, and the principle of universal access to care. The overwhelming majority of specialists practise ethically, transparently and with a deep commitment to patient care – we see this clearly reflected in our own specialist dermatology workforce survey data.

We welcome the current focus on the affordability of care and encourage that these important national discussions proceed constructively – supporting access to safe, high quality specialist care, while recognising and valuing the commitment of the specialist workforce that delivers it.

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APPENDIX

SAFE AND ACCESSIBLE DERMATOLOGICAL HEALTHCARE FOR ALL AUSTRALIANS: THE ACD'S INITIATIVES IN ACTION

All Australians should be able to access timely, safe and geographically convenient skin health and dermatology care. While access to specialist care, including dermatology, continues to be a challenge in some parts of Australia, the ACD has a strong track record of delivering innovative, practical and scalable initiatives that are already working to improve access to safe dermatology care for all Australians.

Growing the dermatologist workforce to meet community need for specialist care



Working with jurisdictional health departments and health services to seek an **expansion of public hospital dermatology services**, incorporating both dermatologists and trainees.



Working with the Federal Department of Health, Disability and Ageing on **implementation of the National Medical Workforce Strategy** and opportunities to build dermatology capacity.



Optimising use of our 34 Federally-funded **Specialist Training Program** positions to increase training in regional areas, and private settings and offer a dedicated position for Aboriginal and Torres Strait Islander doctors.



Implementing **innovative models of training and service delivery** in underserved regions through our **workforce projects** including five funded under the Federal Flexible Approach to Training in Expanded Settings grant program. Find out more [here](#).

Supporting innovative and multidisciplinary care



Identifying opportunities and **securing funding to increase outreach services** that connect with local healthcare providers providing continuity of care between visits and expanding regional/outreach placements and training rotations.



Optimising the use of **emerging digital technologies**, including AI, to support delivery of care, training and interprofessional support, and collaborative and multidisciplinary care.



Supporting GPs, GP registrars, prevocational doctors and nurses to upskill through our **dedicated education arm** [Dermatology Australasia](#)



Continuing to roll-out teledermatology as a model of care, improving access to dermatology services for patients across Australia.

To find out more visit <https://www.dermcoll.edu.au/about/dermatologist-workforce/>