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14 April 2026

House of Representatives
Standing Committee on
Health, Aged Care and Disability
PO Box 6021
Parliament House
CANBERRA
Canberra ACT 2600

By Email: Health.Reps@aph.gov.au

Dear Committee Secretariat,

Re: Inquiry into access to and affordability of medical specialists in Australia

Please find attached my submission to the House of Representatives Standing Committee on Health, Aged Care and Disability inquiry into access and affordability of medical specialists in Australia.

I am a Specialist Anaesthetist practising across public and private settings in Melbourne, Victoria. My submission addresses structural factors affecting specialist access and affordability, with particular focus on Medicare funding design, private health insurance product design and gap scheme mechanics, private hospital viability, workforce planning, and the risks of policy responses that target visible costs without addressing underlying system drivers.

I am happy to provide additional information or to respond to further questions from the committee if that would be of assistance.

Kind regards,

[REDACTED]

Alan

Submission to the House of Representatives Standing Committee on Health, Aged Care and Disability

Inquiry into Access and Affordability of Medical Specialists in Australia

Submitted by:

Dr Alan Tse

Specialist Anaesthetist
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Executive Summary

Access to specialist medical care in Australia is deteriorating because the system increasingly relies on patients to absorb the gap between the cost of delivering care and the contribution made by Medicare and private health insurers.

Over time, Medicare rebates and private health insurance medical benefits have not kept pace with rising practice costs, including staffing, compliance, indemnity, infrastructure and administration. The cost of care has not disappeared. It has been shifted.

Public debate has increasingly focused on visible specialist fees. This is understandable, because specialist fees are often the most visible part of a patient's bill. But they are not the whole story. Patients are also affected by private health insurance exclusions, excesses, restricted insurer benefits, hospital charging structures, and gap arrangements that have become less protective in real terms.

Patients experience the total burden, not just the line item that is easiest to point at.

Australia's public system is already under significant access pressure and does not appear well placed to absorb a major shift of elective and outpatient specialist demand away from the private sector. Private specialists and private hospitals therefore carry a substantial share of the load.

Policy responses focused solely on suppressing specialist fees risk worsening access without reducing total system cost.

The affordability problem is increasingly one of cost-shifting, opacity and system design. Health funds and stagnant public funding settings are central to that problem. Mid-level substitution and expedited pathways may be politically attractive, but they do not solve the underlying constraints of specialist capacity, training, standards, and sustainable workforce distribution.

1. Introduction

I am a Specialist Anaesthetist practising across both public and private settings. My work involves perioperative care for patients undergoing a wide range of surgical procedures, including acute, complex and time-sensitive care.

This submission addresses structural factors affecting access and affordability of specialist care, with a focus on funding design, private health insurance, workforce sustainability, and the risks of policy responses that target visible costs without addressing underlying system drivers.

The perspective provided is grounded in day-to-day clinical practice and reflects how policy settings are experienced at the point of care.

I practise as a specialist in private settings and hold an obvious interest in the policy outcomes this submission addresses. That interest is acknowledged at the outset. The conflicts of interest most relevant to this inquiry, however, are those less visible than a clinician's: the insurer whose premium revenue benefits from inadequate gap cover, and the private equity operator whose returns depend on hospital infrastructure being treated as a financial asset rather than a public good.

2. Relevance to the Terms of Reference

This submission addresses:

- access to specialist care across public and private systems;
- affordability and out-of-pocket costs;
- transparency of funding and insurance arrangements;
- the effectiveness, transparency and equity of referral pathways;
- workforce sustainability and distribution; and
- system-level consequences of current policy settings.

It also considers whether proposed policy responses are likely to improve access in practice, or whether they risk redistributing costs, increasing system complexity, and weakening care delivery while leaving underlying capacity constraints unresolved.

3. A Structural Funding Mismatch

The central issue is a widening gap between the cost of delivering specialist care and the contribution made by Medicare and private health insurers.

Medicare rebates and insurer medical benefits have not kept pace with rising costs. Practice expenses (staff, compliance, indemnity, infrastructure and administration) have increased substantially.

The problem has been compounded by a prolonged policy of indexation suppression. Between 1995 and 2012, MBS rebates increased by only 1.2 to 2.5 per cent annually, well below the rate of growth in practice costs — noting that pathology

and most diagnostic imaging services received no indexation at all during this period. From 2012 to 2017, almost all MBS rebates were frozen entirely, with no indexation. Indexation recommenced in 2017 for GP bulk-billing incentives at 1.4 per cent, but specialist consultations and standard GP attendances did not receive indexation increases until 2019, and those increases have been modest, running at 1.6, 1.5, 0.9 and 1.6 per cent respectively in successive years. The AMA has published analysis tracking the cumulative divergence between Medicare fee indexation and a composite index of average weekly earnings and the Consumer Price Index (reflecting the actual cost structure of medical practice) since 1985. Over that period the practice cost index has risen to approximately four times its 1985 value. The Medicare index has risen to less than twice its 1985 value.

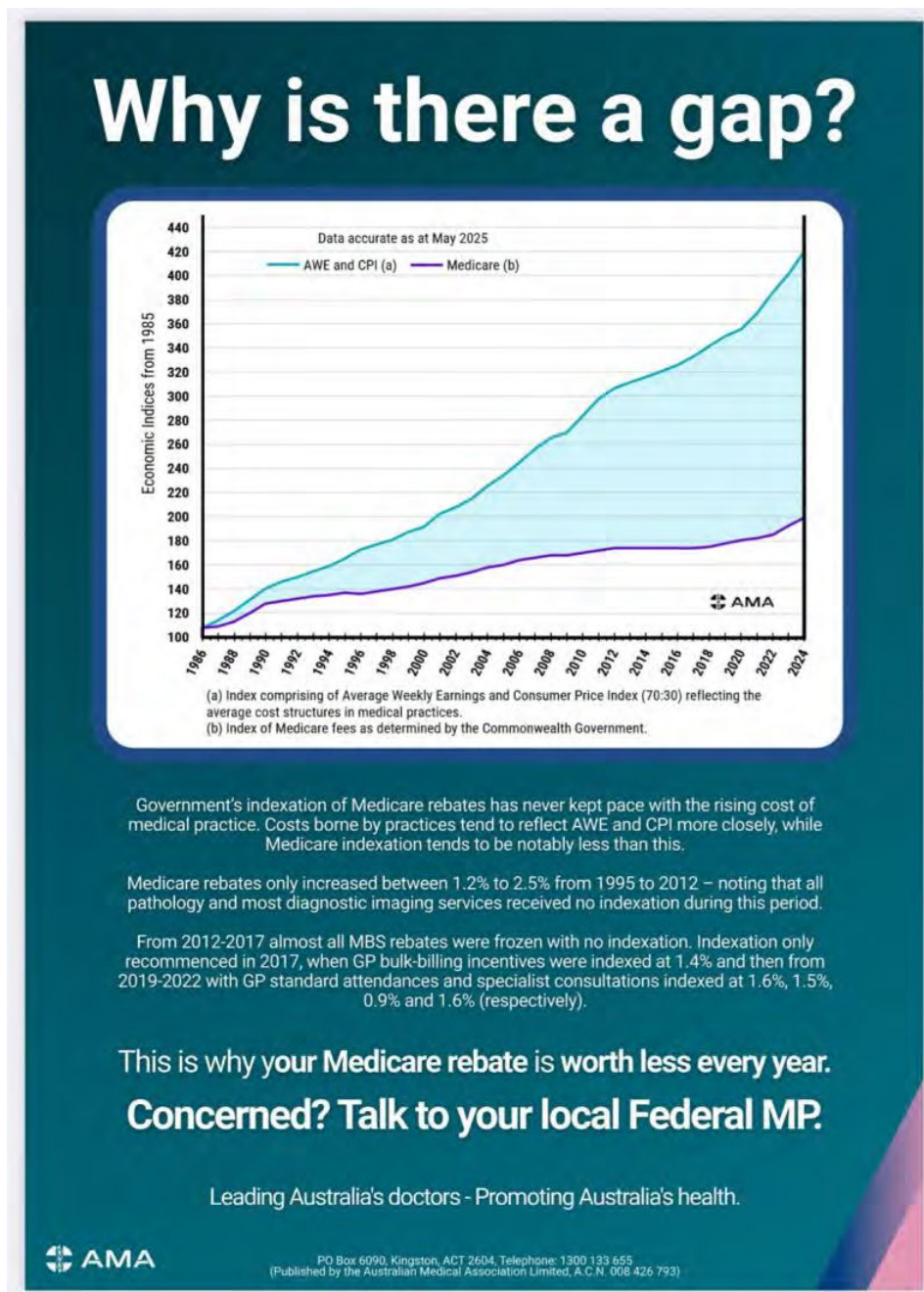


Figure 1: AMA, Why is there a gap? Data accurate as at May 2025. Available at ama.com.au

The gap between these two lines is not a fee problem. It is a funding policy problem, the consequences of which have been absorbed by patients in the form of rising out-of-pocket costs and by practitioners in the form of compressed practice margins.

This gap does not disappear. It is transferred to patients, either directly through out-of-pocket costs or indirectly through delay, uncertainty and reduced access.

That transfer is often politically convenient because it is less visible than explicit public underfunding or explicit insurer under-contribution. But from the patient's perspective, the effect is the same: rising out-of-pocket exposure, increasing uncertainty, and a growing mismatch between what they thought they were covered for and what the system actually delivers.

4. Policy Responsibility Cannot Be Avoided

This is ultimately a policy decision.

Government must decide:

- how much specialist care it funds;
- what insurers contribute;
- what patients pay; and
- how much capacity exists in the public system.

Avoiding these decisions results in silent cost-shifting onto patients.

If funding decisions are not made explicitly, they are made implicitly: by transferring cost and risk to patients.

The current system often avoids honest decisions about who should bear the cost of specialist care. Instead, stagnant rebates and complex insurer product design quietly push that burden outward to patients, while public debate focuses on the most visible charge.

There is a version of this debate in which specialist fees are simply suppressed, private practice becomes progressively less viable, and the shortfall is absorbed by the public system. The committee should examine honestly whether that outcome is available. Australia's public hospital system is not operating with spare capacity. It is under significant pressure in virtually every state and territory. The patients who most depend on public specialist services (those without private insurance, those in rural areas, those for whom out-of-pocket costs are simply unaffordable) are already experiencing the consequences of inadequate public specialist capacity. Adding the elective demand that would shift from a weakened private sector does not help those patients. It competes with them for the same already-insufficient resource.

An ageing population with rising rates of chronic disease, complex comorbidity, and demand for procedural intervention requires more specialist capacity, not less. That capacity requires sustainable funding. Suppressing the visible component of specialist cost without addressing the structural funding gap does not grow the system. It contracts it. The patients who benefit most from a well-funded private specialist sector are not primarily the specialists themselves; they are the patients on

public waiting lists whose waits are shorter because private capacity is absorbing a substantial share of elective demand.

Private specialist practice in Australia operates as a self-funded small business. There is no employer superannuation contribution. Self-employed practitioners fund their own retirement savings with their own contributions to superannuation, though practitioners with fractional VMO appointments may receive superannuation contributions from the employing health service for that component of their work. There is no paid leave, no sick pay, and no institutional backstop if the practice becomes financially unviable. Practice overhead (staff, compliance, indemnity, income protection and disability insurance, infrastructure) is borne entirely by the practitioner. Income is directly tied to clinical activity under personal services income rules that restrict the corporate structuring available in most other professions. Net income reflects training investment, deferred earnings, professional and medico-legal risk, and the real ongoing cost of maintaining a viable practice. A policy debate that treats specialist gross income as equivalent to corporate profit, without accounting for these structural realities, will not produce the access improvements it claims.

The sustainability of specialty training as a career choice is also at stake. Specialist training in Australia takes ten to fifteen years from medical school entry to independent practice. Earnings during that period are well below graduate peers in most professions. Examination fees, training costs, education debt and delayed financial milestones accumulate throughout. The income at the other end of that pathway is not simply compensation for current work. It is part of the implicit contract that makes undertaking that training rational in the first place. If the expected return is materially reduced through rebate suppression, fee regulation, or bundled pricing, the calculation changes not for specialists already in practice, but for the graduates now deciding whether to pursue specialty training at all. The consequences of getting that calculation wrong are not visible immediately. They appear ten to fifteen years later, when the specialists who were not trained begin not showing up.

5. The Private Sector Carries a Large Share of Care

Australia's public system is already under significant access pressure and does not appear well placed to absorb a major shift of elective and outpatient specialist demand away from the private sector.

According to the Australian Institute of Health and Welfare, in 2023–24 approximately 59 per cent of all surgical hospitalisations in Australia occurred in private hospitals. For elective surgery specifically, private hospitals carried 1.7 million of the 2.6 million admissions in that year. This is not a marginal contribution to the health system. It is the primary delivery mechanism for planned surgical care in Australia.

It is also important to note that for out-of-hospital specialist consultations, which represent a substantial component of specialist activity, private health insurance provides no benefit at all. PHI coverage applies to admitted hospital episodes only. A patient attending a specialist in rooms, whether insured or not, faces the same Commonwealth Medicare Benefits Schedule (CMBS) schedule fee and the same

potential out-of-pocket gap. This means a significant proportion of the specialist affordability problem that patients experience occurs entirely outside the private health insurance system and is unaffected by any PHI reform measure. It is a direct and unmediated function of the gap between the Medicare rebate and the real cost of the consultation.

If private practice becomes less sustainable, demand does not disappear. It shifts into the public system as longer waiting times, greater pressure on outpatient clinics, and reduced access to timely care.

This matters because some policy responses appear to assume that specialist private practice can simply be squeezed harder without affecting service supply. That assumption is unsafe. If private capacity weakens, the public system does not receive a windfall. It receives more demand.

It is important to acknowledge that the patients most affected by specialist access problems are often those outside the private system entirely: patients without private cover, those in rural and remote areas, and those for whom out-of-pocket costs are simply unaffordable. These patients depend on public specialist services. Proposals to address this through specialist bulk-billing are not a realistic solution without a substantial increase in Medicare rebates. A specialist consultation requires a minimum of thirty minutes and commonly an hour, and the economics of specialist practice cannot be reconciled with bulk-billing at current rebate levels. The most equitable response is direct investment in public specialist capacity. The Commonwealth has multiple funding and policy levers that influence access and equity in the public system; the appropriate deployment of those levers is a matter for government. What is clear is that a sustainable private specialist sector and well-calibrated Medicare rebates reduce demand on public services and benefit the patients who most depend on them.

6. Private Hospital Viability Is a Structural Policy Problem, Not a Specialist Fee Problem

The risks to private hospital capacity are not hypothetical. The collapse of Healthscope into receivership in May 2025 provides a detailed and instructive case study of what happens when the private hospital system is treated as a vehicle for financial extraction rather than a long-term healthcare asset.

Healthscope began as an ASX-listed Australian company providing private hospital services. In 2010 it was taken private by a consortium of funds managed by TPG Capital and The Carlyle Group. It was re-listed on the ASX in 2014 and subsequently acquired by Canadian private equity group Brookfield in 2019 for approximately \$4.4 billion. At each stage, the ownership structure was oriented toward financial return rather than long-term service sustainability.

The mechanics of extraction were straightforward. Before and during the Brookfield acquisition, Healthscope sold approximately 22 hospital properties to real estate investors in sale-and-leaseback arrangements, realising around \$2 billion. The hospitals continued to operate in the same buildings but now as tenants, paying rent on facilities they had previously owned. Pathology businesses, medical centres, and

other subsidiaries were sold off progressively. What remained was an operational hospital business carrying substantial debt and significant above-market rental obligations on its own former properties, with limited asset backing to weather financial pressure.

When COVID-19 disrupted elective surgery volumes and insurer-hospital contract negotiations deteriorated, the model broke down. By mid-2024 Brookfield conceded its equity was worthless. In May 2025, with \$1.6 billion in debt, Healthscope entered receivership. Receivers were appointed and the Commonwealth Bank injected an emergency \$100 million facility to keep the remaining hospitals operational. Five hospitals were subsequently sold and Northern Beaches Hospital was handed back to the NSW government, raising approximately \$700 million toward repaying lenders. As of the time of writing, a sale process for the remaining 31 hospitals is ongoing, with receivers weighing a proposed not-for-profit conversion against competing commercial offers.

The consequences for patients were immediate and real. Maternity services at Darwin Private Hospital and Hobart Private Hospital were closed prior to receivership, with Healthscope citing financial unviability. Patient safety concerns at Northern Beaches Hospital in Sydney, including the preventable death of a two-year-old child following inadequate triage, were raised in a context of acute financial stress and ownership uncertainty. Northern Beaches Hospital was subsequently handed back to the NSW government, a direct illustration of the systemic consequence this submission describes: private capacity failure resulting in public system absorption. Nearly 19,000 staff faced prolonged insecurity.

This is not an isolated event. It is the predictable consequence of a model in which hospital infrastructure is treated as an extractable financial asset and operational entities are left carrying debt and lease obligations that serve investor returns rather than patient care. The same pattern has been documented in the United States and United Kingdom, where private equity ownership of hospitals has been associated with asset stripping, service reductions, and in some cases closure.

Several broader observations follow.

First, private hospitals are not ordinary businesses. When a retailer or a restaurant fails, the consequence is commercial disruption. When a hospital fails, patients requiring surgery, mental health care, maternity services, or rehabilitation face delayed or foregone treatment. The public system, already under pressure, absorbs whatever demand cannot be accommodated elsewhere. Healthscope's receivership triggered immediate concern from government about the impact on public hospital waiting lists, because with nearly two-thirds of elective surgery performed in private hospitals, any significant reduction in private capacity directly and rapidly flows into the public system.

Second, hospitals under financial stress behave in ways that harm access. They prioritise higher-margin procedures over lower-margin ones. They defer maintenance and capital investment. They close or reduce services that are clinically important but financially marginal, as occurred with Healthscope's maternity services. These decisions are rational from a financial perspective and corrosive from a patient perspective. Financial stress in the private hospital sector does not stay within the sector. It distributes risk and cost across the entire health system and ultimately onto patients.

Third, the regulatory framework has not kept pace with the financialisation of private health infrastructure. There is currently no mechanism to prevent a private hospital operator from selling its property assets, loading the operational entity with debt, and walking away when the model fails, leaving patients, staff, governments, and public health infrastructure to manage the consequences. The United States and parts of Europe have begun to address this through requirements for regulatory notification and approval of ownership changes, restrictions on sale-and-leaseback arrangements involving health infrastructure, and transparency requirements around financial structure. Australia has not.

Fourth, and most directly relevant to this inquiry: the Healthscope collapse did not arise from specialist fees. It arose from leveraged acquisition, asset extraction, above-market rentals on former hospital properties, deteriorating insurer-hospital contract relationships, and financial structures designed for investor return rather than operational sustainability. Directing policy attention at specialist fees while leaving the financial architecture of private hospital ownership unaddressed is not a serious response to the structural risks this inquiry is examining.

The committee should consider whether the current regulatory framework adequately protects patients and the public system from the consequences of financial failure in private hospital ownership, and whether stronger oversight of ownership structures, capital extraction, and service-line decisions is required to ensure that private hospital capacity continues to function in the public interest. In response to concerns raised directly with the Minister in May 2025, the Government indicated it had established a Private Health CEO Forum to bring together industry leaders to discuss proposals for improving sector viability. That response, an industry consultation mechanism, does not address the structural ownership risks the Healthscope receivership exposed, and confirms that a more substantive regulatory framework remains absent.

A further case study: the limits of the no-gap model

A further structural development warrants the committee's attention. The recent opening of Adeney Private Hospital in Melbourne, a joint venture between a group of specialist doctor investors and Medibank's health services subsidiary Amplar Health, operating from a building owned by a real estate investment trust on a long-term lease, has been presented as a model for eliminating out-of-pocket costs. The no-gap commitment to eligible Medibank and Bupa customers is a genuine patient benefit and the model has understandable appeal.

However, the structural concerns it raises should not be overlooked because the immediate patient experience is positive.

First, the model is inherently selective by design. Short-stay elective surgery in a facility with no emergency capacity is only viable for lower-complexity, lower-comorbidity cases. The patients who cannot be treated there (because their condition is too complex, their risk profile too high, or their care requirements too unpredictable) are not served by this model and continue to depend on facilities with full acute capacity. The apparent efficiency of a no-gap elective model is in part a function of patient selection, not system-wide cost reduction.

Second, the absence of emergency capacity creates a structural gap in the continuity of care with direct implications for patients who develop post-operative

complications. Where complications arise, the originating facility lacks the acute capacity to manage them, and funding arrangements between the originating insurer and receiving private facilities may not cover the complication episode, leaving the patient reliant on the public system at precisely the moment they most need private cover. A no-gap promise at the point of elective admission is not the same as a no-gap promise across the full episode of care. Whether this distinction is adequately disclosed to patients before consent is a matter the committee may wish to examine. Current disclosure requirements do not appear to mandate it.

Third, vertical integration between an insurer and a hospital operator raises legitimate questions about clinical independence that should not be dismissed because the immediate financial offer to patients appears attractive. The Australian Private Hospitals Association has noted publicly that under this model, treating clinicians are in a structural relationship with the insurer funding their facility, and that the implications for clinical decision-making deserve scrutiny. A Harvard University-led study of physician-insurer integration found that physicians in vertically integrated arrangements significantly alter their care processes in ways that reflect financial incentives. These concerns are reasonable regardless of the intentions of the participants.

Fourth, and most critically from a system-wide perspective, this model is not replicable at scale and its expansion would actively undermine the viability of the broader private hospital system. A facility that accepts only lower-complexity elective cases concentrates the profitable, predictable end of the case mix while leaving higher-complexity, higher-cost, and emergency cases to other facilities. Full-service private hospitals depend on cross-subsidy between case types; the revenue from straightforward elective procedures helps sustain the infrastructure, staffing, and capacity required to manage complex and acute care. Selective facilities that extract the profitable cases without bearing the costs of full-service care weaken the financial foundations of the hospitals that do. If this model were replicated widely, full-service private hospitals would face increasing financial pressure with a progressively depleted revenue base. The consequence would not be a system-wide reduction in out-of-pocket costs. It would be accelerating financial stress in full-service private hospitals, reduced access to complex care, and increasing dependence on the public system. This is not a model that can be sustained at system scale. The model does not reduce total system cost. It redistributes it from patients treated at the selective facility, who receive no-gap care for straightforward procedures, to patients at every other private hospital whose financial viability depends on the elective case mix that selective facilities have extracted.

This model should not be presented to the committee as a transferable solution to the access and affordability problem. It serves lower-complexity elective patients insured with specific participating funds. It does not resolve the underlying funding architecture of the broader private health system, it does not serve patients who are most complex and expensive to treat, it does not protect patients from funding gaps when complications arise, and it cannot be replicated at scale without degrading the viability of the full-service hospitals the system depends on. The committee should consider whether current disclosure requirements adequately inform patients of what the no-gap promise does and does not cover before they consent to a procedure.

7. Visible Fees Are Not the Same as Total Cost

Specialist fees are highly visible. But they are only one component of total patient cost.

Other drivers include:

- insurance premiums and exclusions;
- excesses and co-payments;
- hospital and prosthesis costs; and
- insurer benefit design.

A patient's financial experience reflects the interaction of all these elements.

Focusing on the most visible cost risks missing the most important ones.

Specialist fees are easy to point at because they are quoted, discussed, and often emotionally salient. But patients do not experience affordability one line item at a time. They experience the total financial burden of the episode.

8. Private Health Insurance Is Too Opaque

Patients frequently believe they are “covered” but later discover:

- exclusions;
- limited medical benefits; and
- large gaps despite insurance.

Private health insurance increasingly gives many patients the experience of being insured, but not protected.

This is not primarily a failure of consumer understanding. It reflects the way products are designed and communicated.

Patients are often reassured that:

- their procedure is “covered”;
- their hospital is “covered”; or
- their doctor participates in a gap scheme.

However, this reassurance frequently does not extend to:

- all providers involved in care;
- all services performed during an episode;
- the level of insurer contribution; or
- how sensitive out-of-pocket costs are to small variations in fees.

Even fund checks may confirm eligibility without providing meaningful certainty about final costs.

This creates a gap between what patients believe they are protected from and what the system actually delivers.

The opacity is not accidental in effect, whatever its origin. It allows health funds to market the appearance of protection while leaving patients exposed to complexity they are poorly placed to understand in advance. A system that allows patients to be technically insured yet practically unprotected is not functioning as it should.

A further concern relates to the conduct of some funds in response to rising costs. Rather than advocating for adequate Medicare rebate indexation or increasing their own benefit contributions to reflect the real cost of care, some insurers have instead directed communications at patients encouraging them to pressure their treating specialists to participate in no-gap or known-gap arrangements. This approach is ethically troubling. It places patients, who are often anxious, unwell, and poorly placed to understand the financial mechanics involved, in the position of commercial proxies for the insurer. The clinical relationship between a patient and their specialist is not an appropriate mechanism for resolving a funding dispute between an insurer and the health system. Using patient distress to achieve commercial compliance is, in substance, unconscionable. It reflects a system in which the interests of the fund have been allowed to displace the interests of the patient the fund is supposed to protect.

A further distortion arises from basic private health insurance products whose annual premiums, when taken with a sufficient excess, can be set below the individual's Medicare Levy Surcharge liability, making it economically rational to take out cover rather than pay the surcharge. The MLS applies at one per cent of income for those above the threshold of \$101,000 for singles and \$202,000 for families in 2025–26, rising to 1.25 and 1.5 per cent at higher income tiers. For a single earner at the threshold, the annual MLS liability is approximately \$1,010. A basic product with a high excess can be structured to cost less than this, creating a straightforward fiscal calculation in favour of insuring. Some holders understand this is a purely fiscal calculation and hold no expectation of meaningful coverage. Others hold a reasonable belief that they are genuinely insured against significant health costs.

In practice the coverage is severely limited. Basic products typically exclude or restrict a wide range of common surgical categories including joint replacements, cardiac procedures, spinal surgery, and dialysis. Even where a clinical category is listed as included, coverage does not extend automatically to every MBS item number billed within that category. A surgical episode routinely involves multiple item numbers, and the coverage status of each can differ. A fund may confirm that one item is Included while another in the same episode is Restricted or Excluded. Since a treating team cannot selectively submit only the favourable items, the coverage status of the least-covered item effectively determines the financial outcome for the whole episode. An Excluded service attracts no PHI hospital benefit at all. A Restricted service attracts only the minimum government-mandated benefit, which product disclosure documents themselves warn is unlikely to cover hospital costs. This is not a theoretical concern; it is a routine clinical experience. The full picture is frequently unavailable at the time of booking and may only emerge on the day of surgery, at which point the patient faces the choice of proceeding and absorbing an unexpected and substantial bill, or cancelling an already-scheduled procedure.

Even where a fund check is completed in advance, it may not clearly flag that the policy is a basic product with severely limited coverage. The treating team may be

told the patient has hospital cover and proceed to seek informed financial consent accordingly, only for the claim to be processed at the CMBS schedule fee, or not at all, because the procedure was Excluded and no PHI benefit applied. The result is a follow-up invoice arriving after the procedure has been performed. This is distressing for the patient, professionally embarrassing for a treating team that acted in good faith, and entirely a consequence of product design and fund check disclosure failure rather than any error in clinical billing practice.

This is not a failure of clinical administration. It is a product design and regulatory failure. Policy settings that count basic product holders in participation statistics as evidence of a functioning private health insurance system are measuring something closer to tax compliance than genuine patient protection.

A strong private health insurance system remains important to overall system capacity, and increasing participation is a legitimate policy objective. However, current settings risk prioritising headline coverage rates over meaningful financial protection. Where participation is driven primarily by avoidance of the Medicare Levy Surcharge rather than access to care, patients may hold insurance that does not materially reduce their exposure to out-of-pocket costs.

The tiered product labelling introduced in 2019 (basic, bronze, silver and gold) was designed to make inclusions and exclusions easier to identify. In practice, the framework has generated a proliferation of products that adds complexity rather than reducing it. Bupa, for example, currently lists over thirty distinct retail hospital products across the four tiers in its March 2026 hospital covers guide for providers, including multiple "plus" variants within each tier. Two products carrying the same "Silver Plus" label from the same fund can have materially different exclusions. The "plus" designation indicates only that the product exceeds the minimum tier requirement in some respect; it provides no standardised guarantee of what is additionally covered. A patient who has chosen what they believe to be a mid-tier or premium product cannot determine their actual coverage for a specific procedure without reading the product disclosure statement and in many cases contacting the fund to check individual MBS item numbers. The reform added labels. It did not add clarity.

Policy should not simply incentivise more people to hold insurance. It should incentivise insurance that functions as genuine protection at the point of care.

9. Known-Gap and No-Gap Arrangements No Longer Provide Reliable Protection

Gap arrangements are presented as a mechanism to protect patients from unpredictable out-of-pocket costs. In practice, that protection has weakened significantly.

Under most arrangements:

- no-gap schemes apply where the specialist accepts the insurer's benefit as full payment;

- known-gap schemes allow a capped patient contribution, commonly around \$500 per doctor per episode of care.

These arrangements are widely understood as providing certainty. They no longer reliably do so.

1. The cap has eroded in real terms and functions as a cliff edge

The known-gap threshold of approximately \$500 per doctor per episode of care has not been meaningfully updated for many years. It was unchanged when I commenced specialist practice in 2012 and remains so today. Funds that previously offered more generous arrangements have over time coalesced toward this figure as an effective ceiling. In that period, staffing costs, compliance obligations, indemnity premiums, and infrastructure expenses have risen substantially.

What makes this particularly consequential is the way the threshold operates in practice. It is not a sliding scale. It functions as a cliff edge.

To illustrate this with real billing data drawn from clinical practice, consider a standard anaesthetic episode for a laparoscopic procedure. The episode comprises three MBS items: item 17610 (a pre-anaesthetic consultation), item 20806 (the anaesthetic item for the laparoscopic procedure), and item 23112 (an anaesthetic time item for a case running between 2 hours 31 minutes and 2 hours 40 minutes, attracting 12 time units). The combined CMBS schedule fee for these items is \$489.85.

The figures below are used by way of example, applying Medibank's current gap cover rates. Other funds offer different arrangements but the differential is not significant, and the structural mechanics described apply across the industry.

A brief explanation of anaesthetic fee-setting is necessary to understand the scenarios that follow. Anaesthetists do not set a single quoted price in the way a tradesperson or consultant might. Fees are determined by applying a unit value derived from the relative complexity and duration of the case to each MBS item, producing a total fee that reflects the clinical work performed. The known-gap threshold creates a structural problem. Where the total fee falls within the threshold, the patient receives the enhanced known-gap benefit. Where it does not, the enhanced benefit is lost entirely. A clinician can of course choose to charge less than what their costs justify in order to preserve the patient's access to the higher known-gap benefit, and many do, effectively subsidising the insurer's benefit structure from their own foregone income. But this is not a sustainable model as costs rise and the threshold remains static, and it is not a reasonable expectation of any professional providing a skilled service.

The alternative, setting a total fee that reflects actual costs without reference to the known-gap threshold, is becoming more common across some surgical specialties, where participation in gap schemes is increasingly difficult to sustain as the gap between the static threshold and rising practice costs continues to widen. Practice varies significantly: some practitioners remain within the known-gap limit, absorbing the shortfall from their own margins; others have moved to setting a total fee, with the patient recovering the CMBS schedule fee from their fund.

The CMBS schedule fee is the floor, not the ceiling; funds can and do choose to pay above it. At least one fund currently offers a product tier that pays benefits at AMA

schedule rates for a higher premium. That such a product exists demonstrates that more generous fund contributions are financially viable. That it remains the exception rather than the norm reflects a deliberate industry choice. The profits of private health insurers are not separate from patient care; they are extracted from the same premium pool. Every dollar directed toward management expenses, shareholder returns, or retained profit is a dollar not returned to patients as benefits. This is not an abstract concern: industry data shows that the proportion of premium revenue returned to patients as hospital benefits fell from around 90 per cent before the pandemic to approximately 83 per cent in 2022–23. In correspondence with the author in June 2025, the Department of Health confirmed the ratio had fallen to this level and was partially recovering, while noting the recovery was not uniform across insurers, meaning some funds were performing materially worse than the aggregate figure suggests. Profit and adequate patient protection are not impossible to reconcile, but they are in genuine tension. In the current system, the balance has shifted consistently in favour of the fund and against the patient.

This trajectory, away from structured gap scheme participation toward unstructured total fee billing, is a predictable consequence of allowing the known-gap threshold to erode in real terms for more than a decade while insurers have prioritised premium competitiveness and profit margins over the benefit levels that would make gap schemes viable for practitioners to sustain. It is not a failure of specialist conduct. It is a failure of system design and of regulatory oversight that has allowed a system nominally designed to protect patients to function primarily in the interests of those who profit from it.

Scenario 1: within known-gap rules

The specialist assigns a unit value producing a total fee of \$1,309.05, generating a known gap of \$500.00. The fund pays an enhanced gap cover benefit of \$809.05, substantially above the CMBS schedule fee of \$489.85, and the patient's out-of-pocket cost is \$500.00. Within known-gap rules: Yes.

Scenario 2: a marginally higher total fee, outside known-gap rules

The specialist sets a total fee of \$1,310.00, just \$0.95 more than the Scenario 1 fee of \$1,309.05. The scenarios are deliberately constructed to illustrate the cliff edge mechanic: the precise reasonableness of either fee is not the point. The point is that a difference of less than one dollar in total fee produces a difference of \$320.15 in what the patient pays, because crossing the threshold removes the enhanced benefit entirely.

The comparison is striking. A difference in total fee of less than one dollar, \$0.95, produces a patient gap that is \$320.15 higher. In Scenario 1 the fund contributes \$809.05 toward the patient's care. In Scenario 2, with a total fee only marginally higher, the fund contributes only the CMBS schedule fee of \$489.85. The fund's saving of \$319.20 is almost entirely transferred onto the patient, whose out-of-pocket cost increases by \$320.15.

This is not a theoretical construct. It reflects the actual mechanics of gap scheme billing as documented in everyday anaesthetic practice using standard billing

software and current MBS item values. The relationship between what a clinician charges and what a patient pays is not smooth, proportional, or visible to the patient. It is binary, insurer-controlled, and essentially invisible until the bill arrives.

2. Poor transparency compounds the problem

Patients are rarely informed:

- how sensitive their costs are to thresholds;
- whether all providers involved in their care fall within schemes; or
- what happens if a provider sits just above the limit.

From the patient's perspective: "I was insured, but I still received a large and unexpected bill."

That experience is corrosive. It undermines trust not only in the insurer, but in the entire funding system around specialist care.

3. Incentives created by the system

The current structure:

- pressures clinicians to remain within outdated thresholds;
- allows insurers to maintain the appearance of protection; and
- transfers financial risk to patients.

This is not an explicit policy decision, but it functions as one. Clinicians are effectively pushed to absorb rising costs or risk exposing patients to sharply higher gaps. Insurers, meanwhile, preserve the optics of cover without meaningfully updating protections to reflect the cost of delivering care.

4. System consequences

Where thresholds remain static while costs rise:

- participation narrows;
- care becomes harder to deliver within system constraints; and
- access is affected.

This matters because the policy consequences do not stop at billing. They affect service availability, workforce willingness, and the sustainability of participation in private specialist care.

5. Policy implication

A protection mechanism that has not been updated in over a decade, erodes in real terms with each passing year, and produces sudden and unpredictable cost shocks for patients cannot be considered effective consumer protection.

10. Clarifying the Main Counterarguments

Before addressing the specific counterarguments, this submission acknowledges directly that some specialist fees are higher than complexity, time, or cost can justify, and that some practitioners do not give adequate informed financial consent to patients before elective procedures. Those cases are real, they harm patients, and they warrant consequences. The informed financial consent framework proposed in this submission provides those consequences, without suppressing fees for the substantial majority of practitioners who set responsible charges for legitimate clinical work.

It is also true that every structural recommendation in this submission, if adopted, would benefit private specialists: higher Medicare rebates, no fee controls, no bundled pricing, no mid-level substitution at scale, scrutiny of ownership models that compete with traditional private practice. The committee is entitled to weigh those interests accordingly. What the committee should also examine is what the alternative produces. Fee suppression, bundled pricing, expanded mid-level substitution, and accelerated overseas recruitment do not increase the volume of specialist care available in Australia. They reduce it, by making specialist practice less viable for complex or time-intensive work, by making specialty training a less rational career investment, and by concentrating viable private practice in metropolitan areas while regional and rural access deteriorates further. The question is not whether specialists benefit from adequate funding. They do. The question is whether the alternative serves patients better. The evidence in this submission suggests it does not.

The minority of practitioners who charge fees that cannot be justified by any legitimate measure are real and visible. They are not representative of a profession in which most practitioners operate as self-employed small business owners, carry the full cost of practice overhead and indemnity, and face medico-legal risk on every clinical decision. Policy calibrated to the outlier imposes costs on the system as a whole and ultimately on patients who depend on that system. Notably, Professor Yuting Zhang, the health economist whose gap-fee data has been most widely cited in this debate has herself stated publicly that fewer than five per cent of specialists are charging fees that could be considered extreme, and that most doctors are charging a reasonable price.

The question of what specialists owe in return for adequate funding is fair and deserves a direct answer. The existing professional obligations are substantial and largely absent from public debate: college fellowship maintenance (a practical requirement for any specialist with public appointments or supervisory responsibilities), ongoing continuing professional development, AHPRA registration, professional indemnity insurance, income protection and disability insurance, and full legal and ethical duties of care to every patient. Professional body subscriptions alone can readily exceed \$10,000 annually, and meeting ongoing CPD requirements adds further cost depending on how that obligation is discharged. The cumulative cost of maintaining specialist standing represents a substantial and largely invisible overhead that policy discussions rarely acknowledge. Most specialists set fees that reflect the cost of their practice, their training investment, and the clinical risk they carry, not a calculation of what the market will bear. The informal access subsidy noted by the Council of Presidents of Medical Colleges, where higher fees paid by patients with greater capacity to pay enable some specialists to reduce or waive fees

for those in hardship, happens largely without policy support or public recognition. It exists because most practitioners who chose a decade of difficult training did so because they wanted to provide good care.

That said, good intentions are not an accountability framework. This submission proposes two obligations the profession should be required to meet. First, informed financial consent before every elective procedure with capped fee recovery as the consequence where that obligation has not been met. Second, financial disclosure through the clinical correspondence pathway to the referring general practitioner, creating transparent patient-specific cost data through the referral relationship. Both obligations run against short-term practitioner convenience. Both protect patients. The submission's structural arguments against fee controls are credible only when accompanied by these genuine professional accountability mechanisms. It is worth noting that institutional self-regulation of this kind already operates in parts of the system: some hospitals impose participation in gap cover schemes as a condition of on-call roster membership, demonstrating that voluntary mechanisms to protect patients from unexpected out-of-pocket costs are both feasible and already functioning.

Rising specialist fees and affordability concerns

It is clear that specialist fees have risen in some areas, and that affordability is a genuine issue. Analyses from policy bodies such as the Grattan Institute and public reporting have highlighted substantial variation in fees, instances where fees exceed Medicare schedule rates by large multiples, and evidence that some patients delay or forgo care due to cost.

These concerns are legitimate and should not be dismissed.

However, they do not establish that specialist fees are the primary driver of affordability problems, nor that fee suppression alone is an effective solution.

Fee variation is real but not yet well understood to justify simplistic policy

Fee variation is real. But variation alone does not indicate misconduct or identify the correct policy response.

Recent work, including that of the Melbourne Institute, highlights that variation in specialist fees may reflect geographic factors, specialty-specific dynamics, supply and demand conditions, referral pathways, case complexity, and differences in practice models.

The policy risk is moving from "variation exists" to "fees should be suppressed" without understanding what is driving that variation. In healthcare, blunt price constraints may reduce participation, restrict service availability, or shift costs and waiting times elsewhere in the system.

The Grattan Institute has cited aggregate specialist clinic cost growth of approximately two per cent annually between 2006 and 2021, slightly below the general inflation rate of 2.2 per cent, as evidence that rising fees are not explained by rising costs. This figure is convenient but misleading. It relies on a 2006 baseline that post-dates the structural gap that had already opened through decades of

below-inflation indexation since 1985. More fundamentally, it uses a general inflation index as a proxy for specialist practice costs, an index that does not capture the cost categories that have risen fastest and furthest for specialist practice specifically. Medical indemnity premiums have increased substantially above CPI, particularly for procedural specialties carrying higher risk profiles. Medical equipment is predominantly imported and priced in foreign currency, exposing practices directly to exchange rate movements and global supply dynamics that bear no relationship to domestic CPI. Compliance costs, driven by regulatory expansion, have risen independently of general price levels. The aggregate figure also masks significant specialty-specific variation, the same methodological problem that undermines fee averaging. An average that includes lower-cost consulting specialties will systematically understate the cost pressures faced by procedural specialists. Using a domestic consumer price index as the measure of specialist practice cost inflation is not a methodologically sound basis for the conclusion that costs do not explain fee growth.

The same distributional problem affects Grattan's other aggregate figures. The health economist whose gap-fee data underpins much of this debate has herself confirmed that extreme fees are charged by fewer than five per cent of the profession. This means the headline average obscures a distribution in which most practitioners are charging within reasonable bounds, and policy built on that average will not solve the problem it claims to address. Grattan's finding that specialist businesses show profit growth of approximately five per cent annually is subject to the same caveat: aggregate profitability across all specialist practice types, sizes, and specialties, from high-volume procedural lists to single-practitioner consulting rooms, does not establish that the practitioners most relevant to access and affordability are generating excessive returns.

Out-of-pocket costs are not determined by fees alone

A patient's financial burden reflects a combination of Medicare rebates, private health insurance contributions, product exclusions and restrictions, hospital and device costs, and the structure of gap arrangements.

Improving transparency around specialist fees alone will not resolve affordability if the underlying funding structure remains unchanged. Targeting the most visible component of cost does not address the least transparent or most distorting components.

Net income versus gross fees

Some policy analysis focuses on specialist net income rather than gross fees, arguing that incomes remain high and therefore justify constraints on rebates or fees. This requires careful interpretation.

Medical income in Australia is typically classified as personal services income, which limits the ability to split income, defer earnings, or use corporate structuring available in other professions. Income is therefore more directly tied to individual clinical activity than it may appear from gross figures.

Specialist training involves a prolonged period of substantially reduced earnings, significant personal financial investment, and delayed career progression. Full income is achieved later in the lifecycle than in most comparable professions

requiring similar intellectual capacity and years of training. It is getting even later now, as medicine has transitioned from an undergraduate to a postgraduate degree, where interrupted specialist training is frequently the norm rather than the exception as decisions must be made about families and other life circumstances as doctors enter training later in life.

Most importantly, net income reflects the cost of maintaining a practice (e.g. staff, compliance, indemnity and infrastructure), the level of clinical responsibility, medico-legal risk, and the personal consequences of adverse outcomes. Specialist income is not simply remuneration for time. It reflects a combination of training investment, deferred earnings, responsibility, risk, and the real cost of delivering care.

The more important question is what happens to the system if income is suppressed beyond what practice economics support. Specialists who cannot sustain viable practices face a binary choice: exit the Medicare system entirely and charge without any rebate applying, creating a genuinely two-tier system that is far less equitable than the current one, or choose careers that better reward their training investment. Australia already graduates doctors at a rate well above comparable countries; the pipeline constraint is not at the entry point. It is at the point where intelligent, highly trained people decide whether the conditions of specialist practice are worth the investment. Compress income below what the investment justifies, without addressing the underlying cost drivers, and the result is reduced supply, not lower costs.

Former federal health minister Wooldridge has warned publicly that direct fee regulation carries the specific risk that specialists with market power would opt out of Medicare entirely, creating a two-tier system fundamentally at odds with Medicare's founding principles. That outcome, a parallel private market operating entirely outside Medicare, would be far more damaging to equity than the current arrangements. This would represent the destruction of the very system that fee regulation is intended to protect. The committee should consider this risk carefully before recommending any mechanism that creates incentives to exit Medicare.

From a patient perspective, either outcome means reduced access: a smaller pool of Medicare-billing specialists, longer waiting times, and increased pressure on an already strained public system.

The National Health Service provides a cautionary example: a system that trains specialists at scale under conditions of suppressed remuneration and constrained professional autonomy generates a cohort for whom international departure becomes a rational career calculation. Australia currently benefits from that dynamic. The committee should consider carefully whether the policy direction under examination risks replicating the conditions that produce it.

Risk and responsibility are integral to healthcare delivery

Specialists make decisions that directly affect morbidity, mortality, disability, and long-term patient outcomes. These decisions also influence downstream use of hospital resources and system costs.

Adverse outcomes may have severe consequences for patients and significant legal and professional consequences for clinicians.

This does not place specialists beyond scrutiny. But it does mean healthcare pricing cannot be analysed as though responsibility, training and risk are irrelevant.

The “inflationary rebate” argument

It is often argued that increasing Medicare rebates may be inflationary, based in part on historical experience such as the Extended Medicare Safety Net. That concern is legitimate.

But it does not justify maintaining a growing gap between rebates and the cost of care. Failure to adjust rebates does not eliminate cost pressures. It shifts them onto patients and may reduce access to care. The appropriate policy response is better alignment of funding with real costs, not indefinite under-indexation. Minister Butler has specifically stated publicly that raising Medicare rebates for specialists is not being considered on the basis that doctors would simply raise their fees commensurately. This claim deserves scrutiny. If true as a general proposition, it would equally apply to any operating cost increase faced by any self-employed professional, suggesting that no economic improvement can ever benefit the practitioner rather than the consumer, an implausible general claim. More importantly, it directly contradicts the government’s own transparency argument: if published fee data creates competitive pressure that drives prices toward the average, the same market logic would limit fee inflation following a rebate increase. It is not coherent to argue simultaneously that the market is competitive enough for transparency to suppress fees and insufficiently competitive for a rebate increase to have any effect other than uniform fee inflation.

The internal inconsistency is sharpened by the government’s own recent policy record. The Commonwealth restructured Medicare payments to strengthen bulk billing incentives for general practitioners on the explicit rationale that inadequate rebates lead to patients forgoing care and that this harms both health outcomes and system costs downstream. It accepted that some of that restructuring would benefit practices rather than being passed entirely to patients, and judged the access benefit worth the trade-off. The argument that increasing specialist rebates would simply feed fee inflation applies, if it applies at all, with equal force to GP rebates. The government has not explained why the policy logic that justified acting on GP rebate adequacy is inapplicable to specialists facing the structurally analogous problem.

The comparison is also not symmetrical: general practice has genuine flexibility in consultation structure, staffing models, and episode design that allows viable bulk billing at current rebate levels. The irreducible time requirements of a specialist assessment (comprehensive history, examination, review of investigations, and formulation of a management plan for a referred patient) do not permit the same adaptation.

Transparency: valuable, but limited in practice

There has been increasing focus on transparency through fee comparison tools and consumer information. Transparency is a legitimate and worthwhile objective, and mandatory disclosure of fees is a reasonable policy measure.

However, transparency has real practical limits that policy should recognise.

It is relatively straightforward to publish fees for initial consultations and standard review appointments. Beyond this, costs become highly dependent on patient-

specific factors, procedural complexity, intraoperative variation, unexpected findings, and team-based care involving multiple providers.

In procedural specialties such as anaesthesia, meaningful cost prediction at the time of booking requires assumptions that may not hold in practice. Anaesthetic time, complexity, and the involvement of additional providers can vary significantly from what is anticipated pre-operatively.

A further structural limitation arises from the multi-provider nature of surgical episodes. A patient providing consent for a procedure typically does so with the surgeon, who may be able to quote their own fee. However, the anaesthetist, surgical assistant, and other procedural providers each bill independently. Surgeons often advise patients that an anaesthetic fee will apply, and in established working relationships there may be a general understanding of what is appropriate. But formally coordinating or pre-disclosing specific fees across a procedural team risks characterisation as price-fixing under competition law. Providers are appropriately cautious about this, and each practitioner has a legitimate interest in setting fees independently. The practical result is that a patient may consent to a procedure knowing a gap will apply, but without any reliable basis for understanding the aggregate episode cost across all treating providers. Fee transparency tools address individual provider charges in isolation. They do not and cannot easily resolve the aggregate cost uncertainty that patients actually experience at the point of consent.

It may be suggested that bundled or episode-based pricing offers a solution to this multi-provider transparency problem. This proposal deserves careful scrutiny, because while it appears consumer-friendly it creates serious clinical and structural problems.

The fundamental problem with bundled pricing in surgical care is not administrative; it is clinical. Safe perioperative care depends on each treating practitioner exercising independent professional judgment on behalf of the patient. The anaesthetist's duty runs directly to the patient: to assess risk independently, to make real-time decisions about technique and monitoring, and where necessary to modify or decline a planned procedure on safety grounds. A financial structure that embeds the anaesthetist's role within a bundle priced and controlled by another party creates a direct conflict between that independent clinical duty and financial incentives operating at the episode level. This is a patient safety concern, not a commercial one.

Bundled pricing is also likely to increase rather than reduce total system costs. Fixed episode prices create strong financial incentives to select lower-complexity cases and avoid high-risk or highly comorbid patients, because complex cases consume more resources within a fixed price. Those patients do not disappear from the system; they are deferred, declined by private providers, or directed to the public system. The practical consequence is that patients who most need timely specialist care face the greatest access barriers under a bundled model, while public hospitals absorb increasing complexity. Apparent efficiency gains in the private sector may reflect case selection rather than genuine cost reduction.

The existing experience with self-funded surgical packages illustrates these risks in practice. In that context, surgeons negotiate package fees with hospitals for self-funded patients, and anaesthetists receive cases allocated to their lists at rates set without their input. Practical refusal is difficult once a patient is booked. This

arrangement already creates pressure on clinical independence, produces fees that may not reflect actual complexity or risk, and places treating practitioners in an untenable position, neither party to the original financial agreement nor free to decline involvement. Extending a version of this model to insured patients across the private system would amplify these problems substantially.

The regulatory framework for bundled pricing in Australian healthcare also does not currently exist. If providers coordinate on sub-bundle allocations, this risks characterisation as cartel conduct under competition law. If insurers set bundle prices unilaterally in a concentrated market, this raises market power concerns in the other direction. Neither pathway is straightforward, and resolving these issues would require regulatory architecture that does not yet exist.

Episode-based payment models do exist in other health systems, but they operate within regulatory frameworks, negotiated insurer-hospital contracts, and workforce structures that are specifically designed around that model and do not currently exist in Australia. Transplanting the pricing mechanism without the supporting architecture does not import the model. It imports the financial incentives without the safeguards.

A more targeted and proportionate approach is available. Where an elective procedure is booked with adequate lead time, each treating practitioner should provide clear informed financial consent before the day of surgery. Where that obligation has not been met and a patient faces an unexpected out-of-pocket cost, it is not unreasonable that fee recovery be limited to a capped or no-gap outcome. This is not merely a theoretical framework; it reflects the current direction of case law. In a decision reported by *Avant Mutual* in March 2026, a court found that where an anaesthetist charged above the Medicare scheduled fee without any prior discussion of fees with the patient, the Medicare scheduled fee was the implied reasonable fee and the practitioner was not entitled to recover the gap payment. The court held that the fact it was common practice for anaesthetists to charge above the scheduled fee did not constitute an implied agreement with the individual patient. It should be noted that this case concerns recovery of the out-of-pocket gap, not the fee itself. Where a fee falls within applicable gap cover arrangements and the patient incurs no unexpected out-of-pocket cost, no dispute arises. The obligation is specifically to protect patients from surprise costs, not to constrain independent fee-setting. Practitioners remain entitled to set their own fees; what the case establishes is that a gap cannot be recovered where no prior disclosure was given. Private health insurers also have a direct commercial interest in ensuring their members are aware of this principle, since a patient who was not given prior disclosure has a basis to dispute recovery of the gap, limiting the fund's exposure and protecting the patient simultaneously. This framework applies to elective procedures booked with adequate lead time.

Emergency care presents a genuine spectrum that the current framework does not adequately address. True emergencies make informed financial consent impossible and no reasonable policy should require it. Urgent but non-life-threatening cases present a more complex picture. The first meeting between anaesthetist and patient may occur in the anaesthetic bay, genuine choice of provider is absent, and the circumstances do not permit meaningful financial negotiation. At the same time, a complex life-threatening emergency procedure carries clinical demands, real-time decision-making under pressure, and professional and medico-legal consequences that differ fundamentally from routine elective work. The practical obligation in these

settings is to provide financial disclosure at the earliest clinically appropriate opportunity; before the procedure where genuinely possible, and as promptly as practicable after it where not. The deeper problem is that the known-gap threshold was set at a level that reflected the cost environment at the time of its introduction and has not been updated since; a problem examined in detail in Section 9. What was proportionate when introduced has become inadequate for complex elective work and bears no relationship at all to the clinical demands of a major emergency procedure. This is a further reason why urgent review and indexation of the known-gap threshold is required.

Independent fee setting by each practitioner is essential to clinical accountability and should be preserved. But that position is strongest when accompanied by a genuine commitment to timely and meaningful informed financial consent for elective procedures. The two are complementary protections that together serve patients better than bundled pricing or unregulated opacity.

Transparency can improve expectations and reduce surprises. But it cannot fully resolve cost uncertainty arising from clinical unpredictability or the structural constraints on multi-provider fee disclosure, nor can it substitute for adequate funding and effective insurance design.

Patients may be better informed and still face unaffordable or unpredictable costs.

The risks of poorly designed transparency extend beyond the structural limits already described. Submissions to the Senate inquiry examining the Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill raised two concerns of direct relevance. The Council of Presidents of Medical Colleges warned that publishing a single average fee per practitioner using historical Medicare data risks creating a de facto industry-standard fee. Over time, published averages produce tacit alignment on higher charges, which is precisely the opposite of the competitive discipline transparency is intended to promote. Avant warned that publishing average fees would mask the "enormous variation" in costs related to patient complexity, anaesthetic needs, hospital differences and geography, and that the data would be 12 to 18 months old, generating stale benchmarks that create unrealistic patient expectations. Avant's submission noted that "if consumers routinely arrive at consultations having seen a government-published figure that differs from the practitioner's quoted fee, which is highly likely, the scheme will generate friction at precisely the point where trust matters most" and that the Medical Costs Finder "risks institutionalising this dynamic at scale." The voluntary Medical Costs Finder scheme has attracted fewer than 100 participating specialists from a workforce of tens of thousands, confirming that the voluntary pathway has not produced the intended result. These concerns argue not against transparency but for designing it well.

There is also a distributional consequence that has received insufficient attention. The CPMC noted that fee variation in specialist practice partly reflects cross-subsidisation; higher fees charged to patients with greater capacity to pay enabling some specialists to reduce or waive fees for pensioners, patients experiencing financial hardship, children, and other vulnerable patients. A published average fee creates structural pressure to converge on that average for all patients, removing the flexibility that currently underpins this informal access subsidy. The patients most likely to lose that subsidy are those least able to manage the difference. A

transparency mechanism that inadvertently removes compassionate fee-setting for vulnerable patients has failed at the most basic level of policy design.

A more targeted approach: financial disclosure through the referral relationship

Standard clinical practice requires specialists to provide a clinical report back to the referring general practitioner following each consultation or procedure. This correspondence pathway could be extended through a standardised financial disclosure field, recording the fee charged, the Medicare rebate, any private health insurance contribution, and the patient's actual out-of-pocket cost for that episode.

The general practitioner would then have accurate, patient-specific, episode-specific financial information for every specialist to whom they refer. This creates genuine transparency through the referral relationship, which is where the relevant professional accountability already resides. A general practitioner who repeatedly receives reports showing patients have incurred unexpectedly large out-of-pocket costs has actionable information: to discuss costs with patients before future referrals, to adjust referral patterns, or to raise concerns through appropriate channels. The transparency is episode-specific, reflecting actual complexity rather than a historical average. It avoids the anti-competitive risk of industry-wide fee alignment. It requires no government database of uncertain timeliness. And it operates through the practitioner with the most trusted relationship with the patient.

This approach would require a standardised addition to existing clinical correspondence practice, a minimal legislative or regulatory change requiring no new infrastructure. It would also give general practitioners the financial information they currently lack when advising patients on the likely costs of a referral before it is made.

The risk of focusing on the wrong problem

There is a significant risk that policy responses focus on the most visible component of the system, specialist fees, while overlooking insurer design and contribution levels, hospital charging structures, prosthesis and device costs, and the broader funding architecture.

This creates a politically attractive but substantively weak response: visible costs are targeted, underlying drivers remain unchanged, and access deteriorates as supply is constrained.

The goal of policy should not be to reduce a single visible component of cost. It should be to ensure that total patient cost is understandable, predictable, and fairly distributed across government, insurers and patients.

11. Expedited Pathways and Mid-Level Providers Are Not an Effective Substitute for Specialist Care

This submission uses the term mid-level providers to refer to nurse practitioners, physician associates, and anaesthesia associates proposed or deployed in clinical roles traditionally performed by specialist doctors. The term does not encompass allied health professionals (e.g. physiotherapists, occupational therapists, speech

pathologists) who operate within well-established and clearly defined scopes of practice, nor does it encompass general practitioners, who hold specialist fellowship qualifications in their own right. The concern here is specifically with proposals to expand non-medically-qualified practitioners into specialist clinical roles, not with the appropriate and longstanding roles of allied health within multidisciplinary teams.

Physician associates and anaesthesia associates are healthcare practitioners who work under the supervision of a doctor and perform clinical tasks including history-taking, examination, ordering investigations, and in some settings procedural work. They do not hold medical degrees or specialist fellowship qualifications. The role was introduced to the United Kingdom in 2003 under the title “physician assistant” before being renamed “physician associate”, a change that itself became the subject of controversy when coronial findings determined the title was misleading to the public, with patients frequently not understanding they were not being seen by a doctor. A subsequent independent review has recommended changing the title again, though medical professional bodies have noted this does not address the fundamental issues of scope definition and supervision responsibility.

There is growing policy interest in expedited pathways and the expanded use of mid-level providers as a means of improving access and reducing cost. While presented as access solutions, these approaches also risk being used as cost-containment strategies through workforce substitution. That matters because policies framed as improving access may, in practice, prioritise visible cost reduction over system effectiveness.

This is not to suggest that non-physician providers have no role. In tightly defined, protocol-driven settings with limited clinical variability, some roles can function effectively within clearly bounded scopes. The issue arises when those models are expanded beyond those conditions and presented as substitutes for specialist care across broader and more complex clinical contexts.

The international evidence

The international evidence on mid-level provider expansion does not provide the reassurance that proponents of these models often suggest. A rapid systematic review published in the British Medical Journal in 2025 by researchers from Oxford University and the London School of Hygiene and Tropical Medicine, written specifically to inform the UK government’s independent Leng Review, found little evidence supporting the safety and efficacy of physician associate and anaesthesia associate roles in the NHS. Almost no research on patient safety existed, many studies involved fewer than ten practitioners, and no studies had directly assessed the safety of anaesthesia associates. The concerning reality is not simply that risks were found. It is that these roles were expanded at significant scale without any adequate evidence base for safety having been established in the first place.

Specific sentinel events have since been documented. A 30-year-old woman died in November 2022 from a pulmonary embolism after twice consulting what she believed was her doctor; on both occasions she had been seen by a physician associate who misdiagnosed her condition. A coroner subsequently issued a prevention of future deaths report following the death of a 77-year-old woman misdiagnosed by a physician associate in an emergency department without medical practitioner oversight, raising concerns directly with the UK Health Secretary and NHS England about public misunderstanding of the role. Freedom of information

data from Manchester University NHS Foundation Trust revealed 44 patient safety incidents classified as never events (serious, largely preventable incidents that should not occur if established guidelines are followed) involving a physician associate or anaesthesia associate between 2020 and 2024, with the number rising from 4 in 2020 to 13 in 2024. One incident was classified as catastrophic. These are not isolated cases. A BMA survey of over 18,000 doctors found that 87 per cent reported that the way physician associates currently work sometimes or always poses a risk to patient safety. A subsequent survey of over 16,000 respondents found that 77 per cent believed NHS leaders could not make the role safe, and only 20 per cent believed that GMC regulation would improve patient safety. The Royal College of General Practitioners has since declared there is no role for physician associates in GP surgeries.

The UK government's own response to this evidence is instructive. The independent Leng Review, commissioned in late 2024, produced 18 recommendations accepted in full, with the government explicitly acknowledging that the mistakes of the past must not be repeated. This is not a vindication of the model. It is a government acknowledging that a workforce policy was implemented at scale without adequate safety oversight, with adverse consequences for patients that are now matters of public and coronial record.

Mid-level substitution is often assumed, but rarely achieved

In many real-world settings, substitution does not replace specialist care; it precedes it. Patients may be assessed initially by a non-specialist provider, undergo preliminary investigations, and still require specialist review for definitive diagnosis or management.

This creates duplication of assessment, additional consultations, and increased use of investigations. In complex care, substitution models frequently add steps rather than remove them. Where specialist input remains necessary, which is frequently the case, total system cost may increase rather than decrease.

The evidence base is also more limited than it is often portrayed. Broad claims that substitution will increase access at lower cost are often made with much more confidence than the evidence warrants.

In perioperative specialties such as anaesthesia, claims of substitution must be treated with particular caution. These models require supervision, carry independent indemnity implications, and introduce further layers of coordination. Where supervision is robust, the supervising specialist remains the limiting factor. Where it is not, patient risk increases.

A further practical constraint applies specifically to private practice settings. Clinical indemnity insurance is priced to the risk profile of the work being performed, not the qualification of the practitioner performing it. A mid-level provider deployed in an anaesthetic or procedural role requires indemnity cover calibrated to the clinical risk of that work; cover whose cost is comparable to that of a specialist performing the same function. When that cost is added to the supervision requirements and coordination overhead that safe deployment entails, the claimed economic advantage of mid-level substitution in private settings largely disappears. The cost saving that is the primary policy justification for mid-level expansion does not survive contact with the actual indemnity arithmetic of private practice.

There is also a structural difference in scope incentives that is rarely acknowledged in policy discussions. Career medical officers and senior medical officers occupy positions that are defined as service roles. There is no professional advancement contingent on expanding scope, no career ladder that rewards performing more complex work. The incentive structure is inherently stable. Mid-level practitioners are individuals with professional aspirations and, understandably, a desire to develop their practice. Scope expansion is not typically a consequence of bad faith; it is a consequence of competent people being available, capable, and motivated to do more. In most fields that is a virtue. In clinical settings where the boundary of competence is invisible to the patient and where exceeding it carries direct risk of harm, it is precisely where adverse outcomes concentrate. The UK evidence does not primarily document institutional decisions to deploy mid-levels beyond their defined scope. It documents the organic consequence of doing so over time.

There is also a fundamental opportunity cost. Resources directed toward parallel mid-level workforces may instead support structured training pathways for registrars under specialist supervision, expanding long-term specialist capacity rather than creating fragmented parallel systems.

The experience of expanded pharmacy prescribing in Australia illustrates a related structural problem closer to home. Where scope expansion is implemented in a model where the financial benefit accrues to the business owner but the clinical and legal risk falls on the individual practitioner, practitioners decline to perform the expanded role, the anticipated access benefit fails to materialise, and the policy objective is not achieved. Scope expansion without appropriate structural alignment of incentives, accountability, and support does not produce the access gains its proponents claim.

Australia should not need to repeat this experience to learn its lessons.

Expedited pathways do not reliably deliver faster access

Expedited pathways for internationally trained specialists are often presented as rapid solutions to workforce shortages. In practice, they do not eliminate the need for supervision, local adaptation, or competency assessment.

The regulator's own material makes clear that the expedited specialist pathway still requires supervised practice, orientation, cultural safety education, and workplace-based assessments, and does not itself confer fellowship. In anaesthesia, ANZCA has made clear that the pathway bypasses the college's usual assessment process but does not remove the need for further local assessment and progression requirements for fellowship.

What is "expedited" is therefore primarily an administrative entry step, not the full set of capabilities and local adaptation tasks required for safe independent specialist practice. The pathway may shorten one administrative step while leaving much of the substantive assessment and transition work still to be completed.

This submission does not oppose the recruitment of internationally trained specialists. They are essential contributors to the Australian health system and will remain so. The question is not who uses this pathway but what it removes, and whether the access claim that justifies removing it is supported by evidence.

It should be acknowledged that some college assessment processes have attracted legitimate criticism as disproportionately burdensome, and that not all colleges have been equally transparent in their requirements or costs. Where genuine barriers exist beyond what clinical safety requires, those should be addressed directly through process reform within the existing assessment framework rather than by removing individual competency assessment altogether.

The existing specialist pathway already accepted overseas-trained specialists with qualifications from comparable systems; it required college assessment to verify that individual clinical competence aligned with Australian practice standards, case mix, and medico-legal frameworks. The expedited pathway replaces that individual assessment with a paper-based qualification comparison conducted by the Medical Board. The Medical Board's own documentation describes this as assessing whether qualifications are based on similar competencies, not whether the individual practitioner's clinical experience and practice patterns are equivalent to Australian standards. ANZCA has noted explicitly that the pathway bypasses existing college assessment processes, with the Medical Board conducting a paper-based assessment before approving practitioners for specialist registration.

There is also specific evidence that qualification comparability cannot be assumed even within approved source countries. The Royal Australian College of Surgeons has identified that UK training in some surgical subspecialties, specifically plastic surgery and ear, nose and throat surgery, is not materially the same as Australian training. A peer-reviewed editorial published in the Australasian Journal of Plastic Surgery in 2025 raised directly whether the pathway's assumptions of equivalence are well-founded. If specialty-specific variation of this kind exists within a single approved source country, the assumption of broad equivalence across the full scope of a specialist qualification warrants scrutiny. There is no published study demonstrating that practitioners registered through this pathway achieve clinical outcomes equivalent to those who completed Australian specialist training or the standard college assessment. The pathway was implemented on an assumption of equivalence rather than a demonstrated finding of it.

There is also a structural concern about the information environment surrounding this pathway. The committee should be aware that a significant proportion of publicly available material explaining this pathway is produced or promoted by recruitment agencies and medical placement companies with commercial interests in facilitating registrations. Independent assessment of patient safety outcomes or access benefit realisation from practitioners registered through this pathway does not appear to have been published. The committee may wish to seek that data directly from the Medical Board and the Department before drawing conclusions about whether the pathway is achieving the access benefits in the communities identified as underserved that justified the removal of the individual competency assessment step.

The committee may wish to examine whether the pathway has produced a materially different geographic distribution of specialist services than the standard pathway would have; whether outcomes data exists or is being collected to assess clinical equivalence in practice; and whether the access benefits claimed have materialised in the communities identified as underserved. The structural factors that lead specialists generally to concentrate in metropolitan areas (e.g. professional networks, subspecialty referral volumes, CPD infrastructure, partner employment,

schooling) apply equally to internationally recruited specialists unless addressed by specific employment conditions or regulation that this pathway does not appear to contain. A committee with medical members is well placed to ask these questions, and to consider whether the pattern here resembles the one already documented in the evidence on mid-level provider expansion: a workforce policy implemented at scale on an access justification, without an adequate evidence base and without independent verification that the safety step removed was unnecessary.

There is also an ethical dimension. International recruitment remains necessary and valuable, but reliance on already-trained specialists from overseas health systems raises questions of sustainability and equity, particularly in a world where workforce shortages are widespread and destination countries are encouraged to build domestic capacity rather than rely excessively on external training systems.

Core policy conclusion

The practical policy issue is not whether expedited pathways exist, but whether they deliver safe, equivalent, and sustainable specialist capacity.

In a system where specialist-level decision-making carries significant clinical risk, the benchmark for independent practice must remain clear, consistent, and defensible. Pathways that alter or fragment that benchmark, without demonstrating equivalent outcomes, risk increasing system complexity while reducing confidence in standards.

Expedited pathways should not be relied upon as a primary workforce solution. Mid-level substitution is not the solution to specialist access. The sustainable solution is to train more Australian specialists, support them properly, and make long-term specialist practice viable where it is most needed.

12. Workforce Sustainability

Specialist care requires long training, high responsibility, and ongoing operational costs. A system that relies on specialist goodwill as a long-term funding strategy is not really funded at all.

Workforce distribution, particularly in rural and regional Australia, is often framed as a simple shortage problem. In practice, it is more accurately a sustainability problem.

Recruitment and retention are strongly shaped by whether specialists and trainees can sustain practice over time. Key barriers include limited professional support, difficulty accessing locum relief and leave cover, reduced peer networks, fewer continuing professional development and training opportunities, heavier on-call burdens, partner employment constraints, and education opportunities for children.

Rural maldistribution reflects not just individual choice but system design.

If governments wish to improve specialist access outside metropolitan areas, they must invest not only in recruitment incentives, but in the practical supports that make long-term rural and regional practice viable. Without these supports, relocation becomes a short-term solution rather than a sustainable workforce strategy.

Smaller centres struggle to maintain services without sufficient workforce depth, while larger regional centres are more likely to retain specialists when they achieve

critical mass across specialties: enough workforce to share on-call burdens, stable supporting infrastructure, and broader professional and personal support networks. Sustainable regional services therefore require coordinated, cross-specialty workforce planning, not isolated recruitment efforts.

It is also important to recognise that not all locations will support full specialist services at all times. Rural generalist models remain appropriate in many settings, and policy should reflect that reality rather than assuming uniform specialist distribution is achievable.

Training capacity is also constrained by funded positions, supervision availability, and case load. States and territories fund the overwhelming majority of specialist training through public hospital systems. Workforce shortages therefore cannot be solved at the point of recruitment alone; they are constrained by training capacity and system design.

13. Workforce Pipeline and Training Capacity: A Structural Bottleneck

Australia's approach to medical workforce planning has become increasingly fragmented across the training pipeline, from university entry through to specialist qualification.

Over time, the number of medical graduates has expanded significantly, including through the growth of full-fee domestic and international places. However, this expansion has not been matched by a coordinated increase in:

- internship positions;
- prevocational training pathways; or
- accredited specialist training places.

Australia is training more medical graduates, but not proportionally increasing the number who can progress to specialist qualification.

A disconnect between training investment and workforce outcomes

Historically, the majority of medical training places were Commonwealth supported, creating a clearer link between public investment and workforce outcomes. That alignment has weakened.

A growing proportion of medical graduates now:

- compete for limited training positions over extended periods;
- undertake additional degrees, research, or unpaid work primarily to remain competitive; and
- experience delayed or uncertain progression to specialty training.

This represents both an inefficient use of human capital and a poor return on national training investment. Training more doctors without providing viable pathways to specialist qualification does not increase specialist workforce capacity. It delays it.

The hidden cost of the “CV arms race”

The current system incentivises junior doctors to engage in activities that are only indirectly related to clinical capability, including:

- low-yield research undertaken primarily for selection competitiveness;
- repeated applications across multiple years; and
- significant personal financial and time investment in credential-building.

While some of these activities have value, much of this effort reflects a selection bottleneck rather than a training need. This is not a deliberate workforce strategy. It is a by-product of constrained training capacity.

Training capacity is a system constraint, not a college preference

Specialist training numbers are often perceived as being tightly controlled by professional colleges. In practice, training capacity is constrained by:

- funded training positions within public hospitals;
- availability of accredited supervisors;
- sufficient case volume and clinical exposure; and
- infrastructure required to support safe training environments.

States and territories fund the majority of hospital-based training positions. Training capacity is therefore fundamentally a health system funding and planning issue, not simply a professional gatekeeping issue.

Reduced case exposure and training intensity

There is increasing concern across multiple specialties that trainees are receiving lower procedural exposure and that case volumes per trainee have declined in some settings. This reflects workforce fragmentation, service pressures within public hospitals, and limitations in training infrastructure.

Workforce expansion requires expansion of training capacity, not dilution of training experience.

Why importing specialists does not solve the core problem

Internationally trained specialists make a valuable contribution to the Australian system and will continue to do so. However, reliance on overseas-trained specialists as a primary workforce strategy reflects a failure of domestic workforce planning.

Importing specialists does not address domestic training bottlenecks, may place additional demand on health systems in source countries, and does not build long-term system capacity. A system that trains doctors but relies on importing specialists to meet demand is not optimally aligned. Former federal health minister Wooldridge has described the structural challenge in direct terms: with a training timeline of fifteen or more years for some specialties, there is simply no economic feedback loop capable of correcting workforce supply and demand imbalances without deliberate planning. He attributed the absence of such planning to every government for a very long time. That assessment remains accurate. In 2014, the Commonwealth abolished Health Workforce Australia, leaving no national

coordinating body for health workforce governance. The consequences of that decision are visible in the pipeline mismatches this section describes.

The pipeline problem and its consequences

These observations point to a deeper structural problem that underlies all workforce planning in Australian medicine. The training pipeline crosses multiple jurisdictional boundaries; universities operating under Commonwealth funding determine graduate numbers, state and territory health systems fund hospital training positions, professional colleges set accreditation standards, and the Commonwealth funds Medicare without directly controlling the supply of practitioners who bill through it. No single entity owns or is accountable for the pipeline as a whole. The consequence is that decisions at each stage are made in relative isolation and mismatches accumulate. Medical school expansion has proceeded because it serves university and Commonwealth interests. Hospital training capacity has not kept pace because it costs state health budgets. The result is a system that produces more graduates than it can readily progress to specialist qualification, with significant waste of human capital and public investment in the process.

The core pipeline problem is not simply too few graduates or too few specialist jobs at the end. It is a mismatch in the middle. Australia has expanded medical school output significantly, graduating at a rate well above comparable countries, without proportionally expanding the prevocational and vocational training positions required to progress those graduates to specialist qualification. The result is a competitive bottleneck that wastes training investment, extends time to specialist qualification, and leaves a large cohort of experienced doctors in a professional holding pattern; performing hospital service roles while waiting for training opportunities that may not materialise.

A further constraint that deserves specific attention is case volume and clinical exposure during training. Reductions in trainee working hours, while appropriate from a fatigue and safety perspective, have a direct and underappreciated impact on procedural and clinical exposure. A trainee working within contemporary hour limits will accumulate substantially less case experience over a given training period than was common in earlier generations. This is not an argument against appropriate working hours. It is an argument that training duration, case volume requirements, and workforce planning must be recalibrated to reflect the reality that trainees are now acquiring experience more slowly than the historical baseline assumed. If the volume of clinical exposure required for competence remains constant but the hours available to acquire it are reduced, either training must be longer, case density must be higher, or training infrastructure must expand to ensure adequate exposure. None of these consequences has been systematically planned for.

It is also worth noting that workforce challenges are not uniform across specialties. Government modelling has projected relative oversupply in some specialties over the planning horizon while others, notably psychiatry (where funded staff specialist positions remain unfilled in some states) face significant projected undersupply. Workforce policy must therefore be calibrated to specialty-specific projections rather than applying uniform pipeline expansion across all disciplines.

The role of experienced non-specialist hospital doctors

A more coherent approach would recognise that a well-functioning medical workforce requires both expanded specialist capacity and a well-supported layer of experienced non-specialist hospital doctors, and that these are complementary, not competing, workforce priorities. This submission is not arguing for fewer specialists. It is arguing that the system needs more of both, and that each requires deliberate planning rather than being left to emerge as a by-product of training bottlenecks and individual career circumstance.

In most states and territories, experienced hospital doctors working in defined non-specialist roles are known as Career Medical Officers (CMOs) or Senior Medical Officers (SMOs). The terminology varies significantly between jurisdictions, with Queensland using SMO, New South Wales and the ACT using CMO, Western Australia using Service Medical Registrar or Health Service Medical Practitioner, and South Australia using Senior Medical Practitioner, among other local variations. Whatever the title, these are fully medically qualified doctors with substantial postgraduate clinical experience, working within defined scopes of practice in hospital settings. They are not the same as mid-level providers. They have the full foundation of medical training, broad clinical understanding, and work under professional accountability frameworks applicable to all registered medical practitioners.

CMOs and SMOs currently absorb part of the pipeline overflow as a consequence of the training bottleneck rather than as a deliberate workforce strategy. This is not in itself a bad outcome. Hospitals need experienced non-specialist doctors to function and already depend on them. But it means these roles carry the stigma of the training bottleneck rather than the recognition of a purposeful career choice. A properly designed and nationally consistent non-specialist hospital doctor pathway would not solve the upstream pipeline problem, but it would serve two purposes. First, it would give doctors who choose or need to remain outside specialist training a legitimate and valued professional home rather than a liminal holding category. Second, and directly relevant to this inquiry, it provides a more appropriate and clinically safer answer than mid-level substitution for the bounded clinical roles that hospitals need filled.

Where the argument for mid-level provider expansion is that defined, bounded clinical roles do not always require a fully trained specialist, the CMO or SMO pathway already provides a more appropriate, safer, and better clinically grounded answer within existing frameworks. Their remuneration is broadly comparable to what mid-level providers would attract. Their clinical foundation is substantially deeper. Investing in this pathway, giving it national consistency, professional recognition, and deliberate workforce planning, is a better answer to the bounded clinical role problem than creating parallel workforces with narrower training, less clinical depth, and greater supervision burden. The mid-level substitution argument is substantially weakened if the non-specialist hospital doctor pathway is properly resourced and nationally recognised.

This potential is currently undermined by the absence of a consistent national framework. The pathway varies significantly between states in its existence, title, remuneration, and professional recognition. It is a reflection of the broader jurisdictional fragmentation that characterises medical workforce planning in

Australia. Pathways that fall between specialist training programs and independent specialist practice tend to fall between policy frameworks as well.

A further practical advantage of the CMO and SMO model is that these roles are explicitly service provision positions rather than positions implying a pathway to specialist training. The medical workforce operates as a pyramid; the system requires more doctors at registrar grade performing service work than it can or should absorb into specialist fellowships. That is not inherently wrong. The problem arises when service positions are structured in ways that create an implied or hoped-for pathway to fellowship that does not materialise for most who hold them, generating years of uncertainty and wasted career investment. A clearly defined CMO or SMO pathway is honest about what the role is and where it leads. It gives practitioners a legitimate and valued professional identity rather than a holding category dressed up as a training opportunity.

Policy implications

Addressing these issues requires a coordinated workforce planning framework that spans Commonwealth, state and territory governments, universities, professional colleges, and hospitals, with shared accountability for outcomes across the whole pipeline rather than at each jurisdictional boundary in isolation. The goal is not to produce more graduates at the expense of specialist training, but to ensure that the graduates produced can progress through a coherent, well-resourced, and appropriately exposed pathway to the level of practice the system needs, and that the full range of medical career pathways, including the experienced non-specialist hospital doctor, is recognised, supported, and planned for nationally.

14. Reform Priorities

1. Align Medicare rebates with actual cost of care, addressing the cumulative impact of prolonged indexation suppression that has seen the Medicare index fall to less than half the growth in practice costs since 1985.
2. Improve insurer transparency and contribution levels. The Committee may also wish to consider whether stronger minimum benefit-return expectations for private health insurers are needed to ensure premium growth translates more directly into patient care rather than administrative complexity. Consider further whether policies eligible for Medicare Levy Surcharge exemption provide sufficient minimum coverage to function as meaningful financial protection.

Mandate that tier labelling (basic, bronze, silver and gold) carries standardised coverage parameters rather than minimum inclusion requirements only, so that products bearing the same tier label are genuinely comparable and patients can make informed choices between funds rather than between incomparable product structures within the same nominal category.

3. Restore meaningful and indexed gap protections, including urgent review of the known-gap threshold which has not been materially updated in over a

decade and which currently operates as a cliff edge rather than a genuine protection mechanism.

4. Require fund checks to clearly disclose whether a product attracts gap cover benefits and whether specific MBS items are Included, Restricted or Excluded, so that treating teams and patients can make genuinely informed decisions at the point of booking rather than discovering coverage limitations on the day of surgery or at the point of billing.
5. Establish informed financial consent for elective procedures as a professional obligation with a defined enforcement mechanism: where a specialist has not provided adequate prior financial disclosure and the patient incurs an unexpected out-of-pocket cost, recovery of that cost above the applicable gap cover rate should be limited to the schedule fee. This is not a fee cap; it is a disclosure obligation. It preserves independent fee-setting for practitioners who meet their obligations and provides a meaningful patient protection consequence for those who do not. The professional obligation runs in both directions: the structural arguments against fee controls are credible only when accompanied by genuine accountability for disclosure failures. This framework is consistent with the direction established in recent case law.
6. Extend the specialist-to-GP clinical correspondence standard to include a standardised financial disclosure field (recording the fee charged, Medicare and PHI contributions, and patient out-of-pocket cost) for every referred episode. This creates transparent, patient-specific cost information through the referral relationship rather than through a government fee database, avoids the anti-competitive risks of published fee averages identified by the Council of Presidents of Medical Colleges, and equips general practitioners to advise patients on likely costs before referrals are made.
7. Improve predictability of patient costs while recognising the structural constraints on multi-provider episode cost disclosure under existing competition law.
8. Expand public specialist capacity, including funded public outpatient and surgical positions, as the most direct mechanism for improving access for patients outside the private system.
9. Invest in domestic specialist training capacity and address the training pipeline bottleneck through coordinated Commonwealth, state and professional college workforce planning.
10. Develop a nationally consistent framework for experienced non-specialist hospital doctors (including Career Medical Officers and Senior Medical Officers) with appropriate professional recognition, remuneration, and career structure, as a safer and more clinically grounded alternative to mid-level provider expansion for bounded hospital clinical roles.
11. Strengthen rural and regional sustainability supports, including locum relief, professional support, and viable cross-specialty service models.
12. Introduce regulatory oversight of private hospital ownership structures, capital extraction mechanisms, and service-line decisions to ensure private hospital capacity operates in the public interest.

13. Avoid policy responses that target only visible costs while leaving structural drivers untouched.
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15. Conclusion

Australia continues to provide high-quality specialist care.

However:

- costs are being shifted, not reduced;
- protections are weakening; and
- policy is increasingly focused on visible components of cost.

Affordability cannot be improved by targeting the most visible cost while leaving the underlying funding structure unchanged. A sustainable system requires explicit funding decisions, not continued reliance on hidden cost transfer.

This inquiry will receive many submissions focused on specialist fees. This submission argues that specialist fees are a symptom, not a cause, and that policy calibrated to the symptom while leaving the underlying structural drivers unaddressed will not improve access, reduce total patient cost, or secure the specialist workforce the system will require over the next two decades.

At present, stagnant Medicare indexation and inadequate insurer contributions are major structural drivers of patient cost. Health fund product design and gap scheme mechanics frequently obscure rather than reduce financial risk. The financialisation of private hospital infrastructure, as demonstrated by the Healthscope receivership, creates systemic risk that no amount of specialist fee transparency will address. No-gap models built on selective case acceptance and insurer vertical integration are not scalable solutions. They redistribute risk rather than eliminating it. Specialist fees are not the sole or primary policy problem they are often presented to be.

Transparency may be helpful, but transparency alone does not correct weak insurer protection, stagnant rebates, or structural workforce bottlenecks. Bundled pricing is not a transparency solution. It is a pricing control mechanism that would compromise clinical independence, distort case mix toward lower-complexity patients, and likely increase total system costs.

Mid-level substitution is not the answer to specialist access. The evidence from NHS implementation is compelling: expansion of non-medically-qualified practitioners into specialist clinical roles has proceeded without adequate safety oversight, has produced documented patient harm, and has been acknowledged by the UK government itself to represent mistakes that must not be repeated. Expedited pathways do not resolve the underlying workforce and standards problem. A stronger, safer and more sustainable solution is an Australian-trained, specialist-led model supported by honest funding, meaningful patient protection, realistic workforce planning, and a regulatory framework that ensures the private hospital system serves patients rather than investors.

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