



ANZCA
FPM

Department of Health, Disability and Ageing

SPECIALIST AFFORDABILITY: OPTIONS TO ADDRESS EXCESSIVE FEES

Australian and New Zealand College of Anaesthetists
(ANZCA) consultation response

15 October 2026



About ANZCA

The Australian and New Zealand College of Anaesthetists (ANZCA), including the Faculty of Pain Medicine (FPM), is the professional body responsible for the postgraduate training programs of specialist anaesthetists and specialist pain medicine physicians.

We are one of the largest medical colleges in Australia and New Zealand with more than 10,000 fellows and trainees.

A key role of the college is fostering the highest standards of clinical practice, safety and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. We do this through our robust training programs, rigorous standards, continuous education, mentoring and supervision of junior doctors, advocacy, and research.

Consultation scope

ANZCA welcomes the opportunity to respond to the Australian Government's Department of Health, Disability and Ageing Consultation Paper: Options to address excessive specialist fees. The consultation aims to examine variation in fees for specialist medical services. The outcome of this consultation has said to inform the development of methods to identify "excessive" fees for specialist medical services and identify opportunities for intervention, as well as contributing to broader specialist affordability and access items.

Being an organisation, ANZCA has provided a general response to the consultation paper, rather than responses to the "provider" or "general public" questions outlined by the department.

Executive summary

ANZCA supports the government's objective of ensuring patients have affordable, transparent and equitable access to high-quality specialist care. Genuinely excessive or exploitative fees are inconsistent with ethical medical practice and should be addressed.

However, excessive charging and the broader affordability of specialist care are related but distinct policy problems. The consultation paper acknowledges that excessive fees are charged in a small minority of services and that improving specialist affordability requires multiple policy responses. It also excludes from scope several major determinants of affordability, including public specialist services, private health sector and insurance reform, workforce planning and broader health system reform.

Regulating a small number of extreme fee outliers will not, on its own:

- increase public specialist outpatient capacity,
- reduce waiting times,
- improve Medicare rebates,
- address specialist workforce shortages or maldistribution,
- strengthen referral pathways, or
- ensure that patients can access anaesthesia, multidisciplinary pain services or perioperative care in the communities where those services are needed.

ANZCA therefore recommends that the government:

1. Clearly distinguish excessive fee charging from the broader problem of specialist affordability and access; and evaluate each policy against measurable patient access and affordability outcomes.
2. Publish sufficiently granular, specialty-specific and item-level data before settling a definition or intervention.
3. No single numerical benchmark should determine that a fee is excessive. Statistical thresholds should be used only to identify services or providers for further examination. Any subsequent intervention should be targeted, proportionate, procedurally fair, and informed by the relevant clinical and practice context.

4. Before using MBS benchmarks to identify excessive fees, government should address inequities in item access and rebates, so funding reflects the complexity and value of care.
5. Fee caps should not proceed unless government can demonstrate, through specialty-specific modelling and testing, that they will reduce genuinely excessive charging without increasing lower fees, reducing bulk billing, shifting costs, discouraging complex care or worsening access.
6. Undertake prospective modelling, implementation trials and ongoing monitoring of patient access, bulk billing, provider participation and cost-shifting before introducing a national regulatory model.
7. Engage specialist medical colleges in the detailed design, testing and evaluation of reforms, but should not be responsible for determining individual fees or enforcing fee regulation.

ANZCA does not support endorsing a particular definition, benchmark or regulatory mechanism at this stage. The available information does not provide sufficient assurance that any single proposed approach would improve affordability without creating unintended consequences for patients.

Detailed points

Keep patients and access to care at the centre

ANZCA supports targeted action against genuinely excessive fees. The purpose of any intervention should be to improve outcomes for patients, particularly by reducing unexpected, unreasonable or avoidable financial barriers to necessary care.

The consultation paper does not establish that extreme outlier fees are the principal cause of delayed or forgone care, with the data indicating that fees exceeding three or five times the median occur in a relatively small proportion of services.

ANZCA is concerned that the consultation risks conflating:

- extreme or potentially exploitative charging by a small minority of providers, and
- the broader, system-wide affordability and accessibility of specialist care.

The distinction matters. If the overall reform objective is to improve affordable access, government action must extend beyond fee outliers and address the full patient journey, including referral, availability of services, waiting times, Medicare rebates, private health insurance arrangements, informed financial consent and workforce distribution.

Recommendation 1: Clearly distinguish excessive fee charging from the broader problem of specialist affordability and access; and evaluate each policy against measurable patient access and affordability outcomes.

Underlying data must be available for scrutiny

ANZCA welcomes the paper's recognition that fees can vary between specialties, settings and types of care. However, the data provided is not detailed enough to determine whether the findings accurately reflect anaesthesia services.

It is unclear which services are driving the reported results, how different components of anaesthesia billing have been treated, whether bulk-billed services have influenced the findings, and whether the data has been correctly attributed to the relevant specialty and setting.

These issues are particularly important in anaesthesia, where fees often reflect several elements of care rather than a single service. Clinical complexity and variability are a core driver of anaesthesia fees, it reflects procedure complexity and type, duration of anaesthesia, patient comorbidities and physical status, additional anaesthesia-provided therapeutic and diagnostic procedures, and clinical urgency (elective vs emergency).

Fees are often calculated using a combination of base units + time units + modifiers. This may include after-hours loadings, emergency modifiers, ASA classification modifiers (patient risk level), and/or regional/remote incentives. These modifiers can significantly alter final patient costs and are not always understood.

This means there is high variability between patients/cases with a wide fee dispersion even for the “same” procedure. Looking at one item in isolation may not provide an accurate picture of the overall episode of care and could make normal billing patterns appear unusual.

Before any benchmarks or interventions are introduced, ANZCA recommends sufficiently detailed data is provided and a clear explanation of the methodology used. This should include information on the services analysed, service setting, fees and out-of-pocket costs, bulk-billing, co-claimed services, geographic distribution, and the impact of different analytical approaches.

Relevant specialist medical colleges should also have the opportunity to review and validate the findings before policy conclusions are drawn.

Recommendation 2: Publish sufficiently granular, specialty-specific and item-level data, together with its analytical methodology, and undertake formal validation with relevant specialist colleges before defining excessive fees or selecting an intervention.

No single benchmark can reliably define an excessive fee

The consultation paper identifies three potential approaches:

- case-by-case reasonableness,
- peer comparison using a median or percentile, and
- comparison with the MBS Schedule Fee.

ANZCA considers that none is sufficient on its own.

Reasonableness

A reasonableness assessment is better able to consider the circumstances of an individual service or a case-by-case assessment. However, reasonableness is inherently judgement-based. Without clear principles, appropriate expertise, procedural safeguards and consistency between decisions, providers and patients may have limited certainty about when a fee will attract scrutiny.

ANZCA would therefore support reasonableness only as part of a structured, transparent assessment process, not as an undefined regulatory test.

Peer comparison

Peer comparison may help identify unusual charging patterns but cannot establish, by itself, that a fee is inappropriate.

The median may reflect a market with either generally low or generally high fees. A percentile approach will always identify a defined proportion of services as outliers, even if the underlying difference is small or clinically justified. The consultation paper acknowledges these limitations.

Peer groups must also be genuinely comparable. For anaesthesia, pain medicine and perioperative medicine, appropriate comparison may require consideration of:

- the nature and duration of the procedure,
- patient risk and complexity,
- subspecialty practice,
- metropolitan, regional, rural or remote location,
- in-hours and after-hours care,
- hospital and facility arrangements,
- practice size and operating structure,
- whether care forms part of a multidisciplinary service, and
- the interaction of multiple MBS items.

A statistical outlier should therefore initiate further inquiry rather than automatically trigger a finding, penalty or public label.

MBS Schedule Fee

ANZCA has strong concerns about using a multiple of the MBS Schedule Fee to define excessive charging.

The MBS Schedule Fee is the reference point used to calculate the Medicare benefit, with the benefit being a subsidy to the patient and not intended to cover the full cost of a service.

Accordingly, the Schedule Fee should not automatically be treated as:

- the cost of providing the service,
- the appropriate market fee,
- the contemporary value of the service,
- a measure of clinical complexity, or
- a regulatory ceiling.

The consultation paper also acknowledges that the Schedule Fee may not reflect costs and that its relationship with actual fees varies significantly by item.

This problem is especially relevant where item structures or fees have not kept pace with contemporary care, practice costs or clinical complexity, resulting in a widening gap between rebates and the actual cost of providing specialist care. Presenting only specialist fees without corresponding rebate information risks obscuring the broader drivers of out-of-pocket costs.

Recommendation 3: No single numerical benchmark should determine that a fee is excessive. Statistical thresholds should be used only to identify services or providers for further examination. Any subsequent intervention should be targeted, proportionate, procedurally fair, and informed by the relevant clinical and practice context.

MBS item inequities and affordability

The consultation should recognise that gaps between specialist fees and MBS rebates may reflect structural problems in MBS funding, rather than excessive charging.

Specialist pain medicine physicians (SPMPs) enter the specialty from several primary specialist pathways, including anaesthesia, general practice, rehabilitation medicine, psychiatry, obstetrics and gynaecology, and other recognised specialties. However, access to MBS consultation items is determined by an SPMP's original specialty qualification, despite all specialists completing the same accredited pain medicine training and providing equivalent care.

Many are unable to access longer consultant physician items 132 and 133 and must use items that do not adequately recognise the time and complexity involved in managing persistent pain.

Similar inequities affect perioperative medicine, where rebates for comparable preoperative consultations differ depending on whether care is provided by a consultant physician or an anaesthetist.

Structural inequities within the MBS can also contribute to higher out-of-pocket costs for women, with some female-specific procedures attracting lower rebates despite being more complex or resource-intensive than comparable services for men. These arrangements may affect both patient affordability and the viability and remuneration of women's health services, with flow-on consequences for workforce participation and access to care.

These disparities can undermine the viability of complex, consultation-based services and increase patients' out-of-pocket costs. A policy response focused narrowly on excessive fees therefore risks treating the symptom rather than the underlying drivers of affordability. They also demonstrate why the MBS Schedule Fee should not be used as a standalone benchmark for excessive fees.

Recommendation 4: Before using MBS benchmarks to identify excessive fees, government should address inequities in item access and rebates, so funding reflects the complexity and value of care.

Fee caps present significant risks

ANZCA does not support the introduction of fee caps without substantially more evidence, modelling and consultation. A published cap could become a price target rather than a ceiling. Providers currently charging below the cap could move towards it, increasing costs for a larger group of patients.

Caps could also lead providers to:

- reduce bulk billing or no-gap services,
- shift charges to other MBS items,
- introduce booking, administration or other non-MBS fees,
- withdraw from particular services, patient groups or geographic areas,
- provide fewer complex services, or
- practise outside Medicare.

These risks are particularly concerning in communities with limited provider choice and in fields where complex cases require considerable specialist time.

ANZCA also opposes any mechanism that would deny or reduce the patient's Medicare benefit after the service has been provided. Enforcement should be directed at substantiated provider conduct, not at the patient.

Recommendation 5: Fee caps should not proceed unless government can demonstrate, through specialty-specific modelling and testing, that they will reduce genuinely excessive charging without increasing lower fees, reducing bulk billing, shifting costs, discouraging complex care or worsening access.

Implementation safeguards and evaluation

Before implementing any regulatory intervention, government should undertake a prospective impact assessment covering:

Patient outcomes

- out-of-pocket costs,
- delayed or forgone care,
- unexpected bills,
- access to complex care,
- access in regional, rural and remote areas,
- continuity of care, and
- patient understanding of financial information.

Provider behaviour

- bulk-billing and no-gap participation,
- lower-fee convergence towards a benchmark,
- withdrawal from Medicare,
- movement of fees between items,
- non-MBS charges and deposits, including booking fees,
- service availability, and
- changes in the treatment of complex patients.

System outcomes

- public hospital and outpatient demand,
- private health insurance gap arrangements,
- workforce distribution,
- administrative and compliance costs,
- effects on referral pathways, and
- differences between specialties, settings and geographic areas.

Any model should be reviewed after implementation, with predefined criteria for modification or withdrawal if it worsens affordability or access.

Recommendation 6: Undertake prospective modelling, implementation trials and ongoing monitoring of patient access, bulk billing, provider participation and cost-shifting before introducing a national regulatory model.

Role of specialist medical colleges

ANZCA supports an advisory role for specialist medical colleges in:

- interpreting specialty-specific billing structures,
- identifying limitations in MBS and claims data,
- explaining clinical complexity and models of care,
- developing fair comparison groups,
- advising on principles for contextual review, and
- evaluating the effects of reform on clinical practice.

However, colleges should not be placed in the position of:

- setting individual practitioner fees,
- investigating individual members' billing,
- determining penalties,
- resolving individual patient billing disputes, or
- administering government regulation.

Those functions require statutory authority, investigative capability, procedural safeguards and appropriate separation from colleges' roles in education, training and professional standards.

Recommendation 7: Engage specialist medical colleges in the detailed design, testing and evaluation of reforms, but should not be responsible for determining individual fees or enforcing fee regulation.



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