ANZCA
FPM

Council of Presidents of Medical Colleges (CPMC)

OUT-OF-POCKET COSTS TRANSPARENCY (MEDICAL COSTS FINDER) MAY 2026 CONSULTATION FORUM QUESTIONS

Australian and New Zealand College of Anaesthetists (ANZCA) feedback

27 May 2026

Single Specialist Profile *(A new free-text box for specialists to provide context about themselves)*

1. What context would benefit consumers for specialists to provide?

Concise, standardised descriptions in plain language to help consumers judge fit and affordability before committing to care. Assume this would be up to the individual specialists to provide themselves, with guidance provided from MCF administrators.

Suggested items include:

- Scope coverage of the specialist and their expertise
- Typical patient group and particular patient or condition focus (if relevant)
- What to expect (at the first consultation, next steps, tests/procedures etc.)
- Cost ranges and coverage (what is included/excluded and how costs may vary depending on complexity, comorbidities, or treatment pathway)
- Additional costs commonly incurred
- Information to determine whether the specialist is the right fit
- Where the specialist practices
- Typical waiting time (described rather than quantified if needed)
- Whether the specialist works with other providers (e.g. surgeons, GPs)
- Approach to explaining options, risks, encouragement of questions or shared decision-making.

2. What other caveats or information does the website need to show?

Overall, the website should have necessary information that empowers and upskills patients by explaining costs and how they are created, who contributes what etc.

Necessary caveats or information may include:

- Data methodology caveats
- Caveat that information is a guide only, not a quote and avoiding appearance of definitive pricing
- Highlighting that one “procedure” often involves multiple clinicians, total episode costs may comprise multiple specialists (e.g. surgeon, anaesthetist, assistant etc.)
- Note that higher fees do not necessarily correspond to better outcomes or higher quality care; training standards are consistently high across specialists
- General explanation of how Medicare and private insurance affect costs, including highlighting that out-of-pocket cost cannot be estimated accurately without insurer data
- When patients typically incur a gap payment
- Whether written cost estimates are provided before treatment
- Referral requirements and process (including communication between practitioners and patients)
- Usage of telehealth and in-person
- How billing is handled (e.g. upfront payment, later billing)
- When patients are expected to pay
- Who to contact for billing questions

Data collection and publication process

3. Are there further aspects or details about billing behaviour that need to be considered?

Inherent technical complexity of anaesthesia

Clinical complexity and variability are a core driver of anaesthesia fees as anaesthesia billing is not procedure-based alone, it reflects procedure complexity and type, duration of anaesthesia, patient comorbidities and physical status, and 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 "same" procedure, limits the usefulness of "average" or "indicative" fees for anaesthetists, and small inaccuracies in time capture (as anaesthesia is heavily time-driven) materially affects billing outcomes.

For example, some of our anaesthetists have worked with surgeons who can complete a hysterectomy in an hour, while others may take four hours for the so-called ''same'' procedure. How will differences in surgical duration, theatre efficiency, and turnover time be reflected in the MCF?

Limited choice for anaesthesia

Patients have limited choice when it comes to anaesthetists, they are engaged via the surgeon or hospital. In this instance, anaesthetists' work is very dependent on the respective surgeon and anaesthesia billing is tied to surgical primary procedure and surgeon item numbers.

In some instances, patients meet their anaesthetist just before their surgery/procedure so don't always know or have exposure to this anaesthetist specialist service, or due to urgent or unplanned surgery. This means limited opportunity to compare fees and seek alternative providers.

This all means that anaesthetists may not be directly comparable or selectable in the same way as other specialists.

In addition, the amount of information communicated to the patient will be heavily dependent on the respective surgeon or hospital. Therefore, clear communication should be provided from all respective stakeholders that anaesthetist fees are separate from surgeon and hospital fees.

Geography influencing choice

Fees may be influenced by geography and supply of specialists, patients may not have choice in terms of specialists and based on regional availability. Fewer providers may lead to less fee competition and greater reliance on visiting specialists.

In particular, access to specialist pain medicine services remains limited in many parts of Australia, with significant wait times for multidisciplinary pain clinics and substantial geographic inequity. Therefore, there is a real risk that we end up with specialist pain medicine physicians opting out of using Medicare at all if there are significant caps on consultation fees.

Package fee is not transparent

Any proposal for a packaged fee estimate (i.e. aggregated, end-to-end cost estimate for a medical service or procedure, rather than individual fee components) is intrinsically unworkable. A packaged fee is not transparent and may lead to unreasonable practice. Its inclusion, as well as being unworkable, undermines professionalism in practice, as well as independence of practitioners.

For example, a surgeon potentially advises anaesthetist and assistant to charge less while the surgeons fee is maintained in the "averaged" bundle.

This approach also risks anaesthetists being inadvertently perceived as somehow belonging to, or being an extension of, the surgeon, or in the same category as their assistant.

In addition, the extent of associated radiology and pathology needs are hard to quantify at the commencement.

Pain medicine and ongoing consultations and repeat procedures

The approach may not reflect the full patient journey costs and ongoing/non-procedural care - service-based vs journey-based costing.

Pain medicine often involves ongoing consultations, interventional procedures, longitudinal care plans, multidisciplinary programs and/or repeat procedures, each with different billing rules. The

current referral and treatment system was designed to primarily support management of acute illnesses, rather than chronic and complex conditions which are increasingly becoming more evident. The current MBS settings limit access to complex time-based consultation items for some pain specialists and may disincentivise longer cognitive care. Therefore, billing behaviour is currently shaped by MBS item availability and eligibility rules.

System design and reform should recognise chronic pain as a standalone condition requiring longitudinal care, aligned with contemporary chronic disease management practices. This aligns with ICD-11 International Classification of Diseases (ICD) of the World Health Organization (WHO) officially recognising chronic pain as a distinct, actionable health condition rather than just a symptom.

Disconnection between fees, rebates, and "the gap"

Medicare and insurer rebates are substantially lower than typical fees which leads to frequent out-of-pocket costs ("gap") and variation by insurer and policy.

Unintended consequences of "cheaper" fees

Awareness and developing strategies relating to unintended consequence. For example, some doctors potentially increasing, rather than decreasing, their fees once they realise they are cheaper than the market rate.

Health fund behaviours

Behaviour of the health funds around known gap and no gap products as this is materially different for anaesthetists with various funds, and therefore a direct impact on the patient.

Review process

4. What sort of communications would specialists like to see?

It is unclear what "communications" relate to in this question – whether it relates to communications from consumers, from MCF administrators or other stakeholders/purposes.

Regardless, some general potential communication considerations for specialists include:

- Clear articulation of why MCF matters and how it will be used, methodology scope and coverage, what information specialists need to complete and supporting guidance, and avenues for raising queries and issues.
- Ability to review/view data that will be used in relation to them and process for adjusting it.
- Clear statements about medico-legal and risk guidance on how MCF interacts with informed consent obligations, disclaimers, acceptable ranges or variances, liability protections, safeguards against misinterpretation and inappropriate comparison or ranking, and competition and advertising rules.
- How often data is refreshed/updated, the time lag between service delivery and publication, and processes for updating methodology over time.

5. What additional features would specialists like to see in the MCF portal?

- Perhaps including the **recommended AMA rate as a guide** to acceptable upper limit.
- **Gender should NOT be a search feature.** The potential unintended consequences will be female specialists (surgeons) needing to charge less than male colleagues to attract work.
- **Access to the MCF portal should be gated by GP referral.** Once a consumer has a referral THEN they can access MCF. There are many complex decisions which require discussion with a GP before jumping to cost of procedure.'

- **Consideration of certain biases.** For example, impact on so called ethnic sounding names. We are aware of scenarios where specialists use their married name or maiden name for work due to use of either giving them a different patient base.
- A patient could also indicate with a single click **if the final total fee was within the 'indicative range'**. Over time, with sufficient responses, this could be added to the specialists' information page as a '% in range'. This would only be fair if some indexation or annual updating of indicative fees/range occurred.
- Would be good if there was reference, or move to, key quality or safety elements. It's hard to know how this would be captured/incorporated, however transparency of billing should focus on this over time.

6. What information would specialists like to see covered by the explanation of the methodology?

Clear statement of what the methodology is designed to do and how it aligns with broader system objectives. For example, improve consumer understanding of typical out-of-pocket costs, transparency, informed consent etc. Assume the purpose does not relate to benchmarking of individual performance or a fee-setting or regulatory tool.

For both specialists and consumers, **transparency on data inputs, how out-of-pocket costs are calculated, and inclusion/exclusion criteria** are essential. This includes where there are multi providers in a single episode, how data is presented/aggregated, know data quality limitations and assumptions, and whether the methodology can be independently understood and scrutinised.

The idea of an **indicative range** is important because costs vary relating to patient factors (e.g. comorbidities), procedural complexity, and to some extent the insurer and level of insurance. For anaesthesia, surgical procedural complexity is often reflected in increased time-based costs. Complications may also result in higher fees for a given case (e.g. a need for blood transfusion or advanced monitoring).

It would be helpful for patients to know this so that can better understand why the one specialist would have a range of expected fees for what might superficially seem a similar case. It is also important to communicate that individual costs vary depending on patient complexity, setting type, and provider fee structures and that it may not capture all possible costs (e.g. unexpected complications).

There is a **weakness in only using Medicare data** as this may miss the costs incurred by 'booking fees' (or similar advance payments) if they do not appear in Medicare (or private insurer) records. This could be mitigated over time by having a feature in the app (similar in principle to Google Maps for traffic accidents etc.) where a patient could indicate if a cost was charged which was not associated with an item number (such as a booking fee).

7. What supporting information would specialists need to provide to request a review?

Supporting information that is able to clearly demonstrate that published information is inaccurate, misleading, outdated, and/or not reflective of contemporary clinical practice or fee structures, and that a review is necessary. For example, differences between MCF estimates and actual quotes provided to patients and where these are notably varied.

In closing, ANZCA is very interested in being part of all relevant working groups.

Dr Lance Emerson
ANZCA Chief Executive Officer