Council of Procedural Specialists submission to

Specialist affordability - options for addressing excessive fee charging

The Council of Procedural Specialists is a committee of national procedural specialist organisations who formed to provide a voice for Australian medical practitioners involved in procedural medicine. Members of its constituent organisations practise in both Australia and New Zealand.
The organisations comprising its membership are the Australian Society of Ophthalmologists; the Australian Society of Orthopaedic Surgeons; the Interventional Radiology Society of Australasia; the Australian and New Zealand Association of Oral and Maxillofacial Surgeons; the Australian and New Zealand Society for Vascular Surgery; the National Association of Specialist Obstetricians & Gynaecologists; the Medical Surgical Assistants Society of Australia; and the Australian Society of Anaesthetists.

1. The Council of Procedural Specialists welcomes the opportunity to respond to the consultation paper on specialist affordability.
2. COPS has reviewed the executive summary (10 pages) and the consultation paper (28 pages) which focus on fewer than 1 percent[1] of unspecified "specialist services" which they describe as excessive.
3. COPS does not support or defend opportunistic or exploitative behaviour by any health professional.
4. COPS supports patients being fully informed of, and consenting to, the costs associated with their medical treatment prior to its commencement.

[1] 0.7% of in-hospital specialist services and 0.1% of out-of-hospital specialist services which were charged with fees more than 5 times the median

Background

1. Australia's medical specialists in private practice have set their own fees since the start of European settlement in 1788.
2. The period since has seen a consistent expansion in the private healthcare sector. Australia's 47,147 medical specialists currently deliver around 40 million medical specialist services each year. There are also 21,282 medical specialists in training. Australia's medical specialist workforce has grown at 62% over the last 10 years, or 4.9% annually.[2]
3. Australia's health outcomes, delivered by a balanced public-private system, are considered the best in the world.[3]
4. In April 1995, the Australian parliament adopted the competition framework model. Under this framework, medical practitioners in private practice must independently value their own services.
5. Medical organisations are not permitted to set or recommend fees unless authorised under specific conditions by the ACCC. This includes a prohibition on publishing indicative fee schedules. The AMA Fee Schedule, which is not published for public use, is permitted and recognised. Under the Trade Practices Act, any discussions on medical fees by medical practitioners can be used as potential evidence of collusion, with significant penalties.
6. *"Industry associations need to be careful when dealing with pricing issues, including recommended price lists or fee schedules. When an industry association recommends prices for its members, this could have the effect of price fixing by creating a minimum price that all the competing businesses sell their goods or services at."*[4]
7. All medical services are subject to consumer protection legislation in all states and territories.
8. Cost of living pressures on Australians are well known to Australian medical specialists who come face to face with around a third of the Australian

[2] AIHW - Health Workforce Data
[3] Commonwealth Fund Report Sep 2024
[4] https://www.accc.gov.au/business/selling-products-and-services/tertiary-education-program/cartels-illegal-agreements-between-competitors/types-of-cartels/price-fixing

population each year. Patients present with a range of personal and clinical circumstances and with or without some form of private health insurance coverage.

Affordability of specialist care

1. According to the Australian Bureau of Statistics, the percentage of Australians who delayed or did not seek healthcare due to cost decreased in 2024-25 compared to 2023-24.
    - dental professionals – 16.1% compared to 17.6%
    - medical specialists – 8.6% compared to 9.8%
    - GPs – 7.7% compared to 8.8%
    - hospitals – 2.1% compared to 3.1%.
2. ABS statistics indicate that over the last 15 years, the average percentage of Australians delaying seeing a medical specialist is 8.4% (see Table 1 in the Appendix).
3. This evidence indicates that affordability of dental, medical specialists, GPs and hospitals are long-standing issues for some patients.
4. The Australian public hospital system is designed to provide for the needs of Australians who, for whatever reason, are unable to, or choose not to, access the private healthcare system.
5. Ongoing reduction in public hospital outpatient clinics, due to cost shifting from public hospital budgets (hospital Medicare) to the MBS (medical Medicare), has led to patients who would normally visit a public hospital outpatient clinic having to see private medical specialists. [5]
6. There have been persistent calls for a greater investment in public hospital surgical capacity and outpatient clinics. Dr Michael Freelander, Member for Macarthur & Chair of the House of Representatives Standing Committee on Health, Aged Care and Disability, Hansard 25 March 2026 states *"I would also like to see a huge investment, by federal and state governments, in our public*

[5] "Many of our members have witnessed health bureaucrats and hospital administrators manoeuvring to shift costs between governments; for example, bulk-billing patients attending public outpatient clinics in public hospitals to raise revenue and closing down public outpatient clinics and making follow-up and new clinics occur in private specialist rooms or in staffed specialist private practice clinics." Dr Davoren—The Doctors Reform Society (https://www.aph.gov.au/binaries/hansard/senate/commttee/s858.pdf)

hospital outpatient system, as another way of improving equitable access to health care." COPS supports Dr Freelander's call.

COPS' concerns about the methodology of the consultation paper

1. **The data used does not only cover medical specialist services.** According to the consultation paper, the data presented is a collection of items considered to be "specialist services". However it acknowledges that the data captures services delivered by practitioners other than qualified medical specialists (including pathology and diagnostic imaging). *"For example, the BTOS "Operations" includes complex surgeries potentially only able to be delivered by one speciality but also contains the MBS items for skin excisions which could be delivered by dermatologists, GPs, surgeons, or other various medical specialties. Similarly, items within the BTOS "Anaesthetics" can include anaesthesia type services not delivered by anaesthetists."*
2. **Service level evidence is used to support provider level conclusions.** Figures 6 and 7 measure the proportion and number of individual services charged at multiples of the median or Schedule Fee (MBS). On their own, these figures do not establish what proportion of individual specialists routinely charge high fees, or whether the high fee services are concentrated among a small group of providers.
3. **The affordability evidence does not necessarily establish the impact of the excessive fee tail.** The ABS result that 8.6% of people delayed or did not see a specialist because of cost is evidence of broader affordability pressures, but does not identify whether those patients were exposed to the particular high fee services being targeted in the paper. The paper also notes that this measure has not increased despite rising specialist costs and cost-of-living pressures.
4. **The definition of "excessive" can materially affect the result.** The paper considers multiples of the median fee, multiples of the MBS Schedule Fee and percentile based thresholds. These are not interchangeable benchmarks and can identify materially different services as "excessive". The paper itself

acknowledges that a high median can make a median based threshold very high, while the Schedule Fee may not reflect current market pricing.

5. **Bulk billing and pathology affect the reported fee distributions.** The Department includes both bulk billed and patient billed services in its fee distribution analysis. It acknowledges that excluding bulk billing would increase the proportion above Schedule Fee multiples but decrease the proportion above median multiples, and that excluding predominantly bulk billed pathology services would change the distributions. These sensitivities are not quantified in the paper.

4. **Some specialty comparisons require caution.** Figures 10 and 11 aggregate results at the DMS2 specialty level, exclude some specialties because of low provider volumes, and can also be affected by item modifiers and differences in service mix. This limits how confidently the specialty results can be interpreted as differences in underlying fee setting behaviour.

5. **A number of prominent quantitative claims are not independently reproducible from the information published in the paper alone.** These include the approximately $458 per person out-of-pocket figure, the 72.2% increase in in-hospital gap payments and $323 median gap, the unidentified example of a $595 median versus $1,250 at the 95th percentile, and the statement that some specialist fees have exceeded 50 times the median. These may be valid Department calculations, but the underlying denominators/data are not provided sufficiently to reproduce them independently.

6. **The Grattan Institute comparison uses a different methodology to the Department's service level analysis.** Grattan's "extreme fee" definition is based on provider level average fee-to-Schedule Fee ratios, whereas the Department's Figure 7 analysis classifies individual services according to whether they exceed specified Schedule Fee multiples. The cited finding that more than one in five Australians who saw a specialist were charged an extreme fee at least once should therefore not be treated as directly equivalent to the Department's Figure 7 results.

7. While the Department's descriptive evidence may justify investigation of high-fee tails and improved transparency, **it does not, by itself, establish the prevalence of any unjustified charging by unique practitioners or the causal effectiveness of any proposed intervention**.

What is an excessive fee?

1. The value and affordability of any service is determined by the end user.
2. For people with limited income, even a fee at the lower end of the range may be unaffordable.
3. For a person with high income, a fee at the high end of the range may seem entirely reasonable.
4. The current cost of individualised quality medical services is clearly indicated by public hospital charges for non-Medicare eligible patients. For example, in NSW, student visa holders are charged $1950 per day for inpatient non-critical care and non-student visa holders $2950 per day. Critical care fees are $4900 and $7200 per day respectively.[6]
5. In procedural medicine, the value of the medical procedure to the individual patient will depend on the patient's perception of the benefit of the treatment compared to the cost.
6. Quality procedural medicine is not a standard buy-sell transaction. There are multiple factors, and often unknowns, involved in reaching a successful outcome. It is therefore important that the information given to patients is tailored to the specific treatment pathway. Cheap surgery is not cheap if it delivers bad outcomes. While patients understandably seek to minimise out-of-pocket costs, their overriding priority is achieving a safe and successful surgical outcome.
7. Procedures which involve multiple patient comorbidities and involve greater time, effort and expertise may present on a data sheet as incurring an outlier fee.
8. For all of the above reasons, **there is not and cannot ever be a universal objective pre-determined definition of what is an excessive fee**.

[6] NSW Health Information Bulletin – Scale of Fees for Hospital and Other Health Services, 4 August 2026

9. Historically, guidance to patients and medical practitioners about what fees may be considered reasonable in most circumstances, has been provided by the publication of schedules of medical fees.
10. However, under the competition framework, medical schedules devised by medical associations are not permitted, other than the AMA Schedule, which is not publicly available.
11. As a result, the public has been denied access to indicative fee schedules in various specialties.
12. What is excessive can only ever be determined by an examination by peers of all the individual circumstances involved in delivering a particular service.

The AMA Schedule v the MBS

Procedure	MBS Item Number	AMA fee as a multiple of MBS Schedule Fee
HH 600 - DIVISION OF ACCESSORY PATHWAY	38512	[redacted]x
MG 135 - Amputation at hip	44370	[redacted]x
EJ 705 - ENDOSCOPIC SPHINCTEROTOMY	30485	[redacted]x
HE 300 - PROSTATIC ABSCESS	37221	[redacted]x
MT 620 - SHOULDER, repair of rotator cuff	48906	[redacted]x
MZ 640 - SCOLIOSIS OR KYPHOSIS	50600	[redacted]x
BT 500 - MANAGEMENT OF VAGINAL DELIVERY AS AN INDEPENDENT PROCEDURE	16515	[redacted]x

FA 100 - LUMBAR SYMPATHECTOMY	35000	[redacted]x
MD 410 - OESOPHAGEAL ATRESIA	43849	[redacted]x
AVERAGE of above		**3.22 x**

1. The above table compares the current AMA fee to the MBS (AMA Fee as a multiple of MBS as at June 2026 for 9 randomly chosen procedures).
2. The MBS, although labelled Schedule Fee, is in reality the amount the Commonwealth government is prepared to pay as a subsidy for medical services and is indexed according to government budgetary criteria.
3. The AMA Fee Schedule is recognised by state governments and third-party payers as a schedule of medical fees indexed annually in line with background practice costs.
4. The AMA Fee Schedule increased on average by 33.4% between 2014-2024, with CPI increasing 31.27% over the same period.
5. According to the Grattan definition of excessive fees proposed in the consultation paper, almost all the procedures listed approach or exceed three times the MBS.
6. Hence an obstetrician performing a vaginal delivery and a spinal surgeon operating on a child's scoliosis at the current AMA Schedule Fee would be deemed as charging excessive fees under the 3x MBS definition.

I'm not going to get into arguments about whether they're too much or too little. The reasons for specialist fees can vary. The costs of specialist practice are quite expensive. The training is now very prolonged. Many people go into medicine after a first degree. Their medical degree is their second degree and their specialist qualifications are often their third degree. The costs of running a practice, including insurance, have increased a lot. Rents have increased a lot. Equipment fees, which some specialists, such as ophthalmologists, require have become more and more expensive. The Medicare rebates haven't kept pace with the actual costs of doing medical business, if I can put it that way.

– Dr Michael Freelander, Member for Macarthur & Chair of the House of Representatives Standing Committee on Health, Aged Care and Disability, Hansard 25 March 2026

Peer review of medical fees

1. Whilst peer assessment is currently used for determination of opportunistic behaviour in regard to claiming MBS Item numbers, it is not clear from the paper who would conduct any "peer assessment" and what considerations these assessors would be required to concern themselves with.
2. Would it be a peer group of specialists in private practice from the same specialty? Would it be retired specialists? Would it be the relevant medical college or medical association?
3. What weight would be given to the patient's consent to the fee charged?
4. What criteria and safeguards for procedural fairness would be implemented?

Capping fees

1. It is well known that price fixing in any market does not work. Where prices are artificially constrained, particularly against rising and persistent inflation, the quality of the product deteriorates and/or the supply reduces.
2. Subjecting medical specialist services to an approval mechanism to charge a higher fee may simply delay critical surgery and add to practice costs which

eventually must be passed on. Delaying necessary treatment generates further costs for patients and other payers.

3. Fee capping would also move the issue of medical fees from an individual professional determination into an industrial framework with all the associated liabilities and costs of potential protracted disputes between the medical profession and governments.

The rise of AI and patient access to information

1. Australian patients now have unprecedented access to information regarding all aspects of medical treatment, including the cost of procedures, through AI tools.
2. There is evidence in the US that up to 34% of the population are using AI for health-related research[7] and 20% to gain information on medical bills and health insurance benefits[8]. There is no reason to believe that Australians would be any different.
3. Removing current restrictions on the publication of indicative fee schedules by medical groups would enhance this capability.

COPS supports:

1. The **freedom of Australians** to choose their own doctor without commercial or government interference or coercion.
2. The **independence of the Australian medical profession** to act in the patient's interest, free from the influence or coercion of government or commercial agendas.
3. The **protection of patients via a legal duty of care** which holds all medical practitioners legally liable for all treatment they deliver.
4. The **maintenance of quality standards of medical training, service delivery and ethical behaviour** through independent medical colleges and clinician-led medical registries to support evidence-based medical practice.

[7] US Pew Research Center, August 2026

[8] https://www.techtarget.com/patientengagement/news/366646122/Which-AI-chatbots-do-patients-turn-to-for-medical-advice?

5. The **requirement for informed consent** to all medical treatment and the associated costs before treatment commences, and college-led standardisation of informed financial consent procedures.
6. The **maintenance of Australia's balanced public / private healthcare sectors**, which has resulted in the delivery of world's best health outcomes[9] and has preserved essential freedoms for Australians, including the freedom to choose a medical practitioner.
7. The urgent **expansion of public hospital outpatient clinics** to provide additional medical specialist services to Australians who are unable to afford private specialist services, supported by the **appropriate financing of public hospitals** (Hospital Medicare) and the **Medicare safety net** (Medical Medicare).
8. The **contribution of private medical specialists to the public hospital system** through Visiting Medical Officer (or equivalent) roles, where procedural specialists bear the fixed and ongoing costs of maintaining private practices while undertaking public hospital work.
9. The **removal of restrictions on the publication by medical associations of indicative fee schedules** to inform patients of the range of fees being charged in any particular medical specialty, in addition to the Medical Cost Finder website.
10. The **right of medical practitioners** who have successfully met the qualification requirements to become a medical specialist to establish a private practice and **to independently value their own services** (and hence obtain a return on their investment in education and training) within appropriate consumer protection legislation.
11. **Accountable and transparent fee-for-service medicine** as the most efficient and effective way of ensuring the ongoing supply of quality medical services in the private sector, working alongside and in co-operation with Australia's public hospital system.

[9] Commonwealth Fund Report Sep 2024

12. The principle of **community rated private health insurance** supported by tax incentivised health savings accounts.
13. **Existing state and territory consumer protection legislation**.
14. **Profession-led and appropriately structured peer review as the most effective way of determining whether any particular fee, identified as an outlier, has been appropriate** in the particular circumstances under which the service was delivered.

COPS does NOT support:

1. **Government or commercial intervention into the doctor/patient relationship**, or arrangements that amount to the micro-management or direct or indirect coercion of clinical medicine by third parties.
2. **Opportunistic behaviour by medical or health practitioners** regarding third party payment systems, and/or the exploitation of patients.
3. **The differential rebate scheme** where patients who choose doctors outside insurer preferred provider networks are penalized with lower rebates (larger out of pocket payments). Patients should receive the same rebate for the same medical service regardless of choice of doctor.

Conclusions

1. **Effective regulation of professional behaviour is best achieved when the regulations have the complete confidence and co-operation of the regulated profession.**
2. COPS has raised significant concerns about the methodology used in the consultation papers to interpret data. The consultation papers present evidence of fees in the higher quartile ranges of services but do not give any specific details of what these services are, who they were delivered to, and who they were delivered by. Based on the information presented and the options available, COPS believes that **it is not possible to arrive at an objective and universally applicable definition of what is an excessive fee**.

3. The consultation paper then **asks for agreement to interventions** to address outlier fees, without having justified such intervention, or demonstrated how these interventions would improve the affordability of medical specialist care.
4. The **value of any service**, including medical services, **ultimately lies with the end-user**, in this case Australian patients.
5. **Opportunistic and exploitative business practices are best dealt with by consumer protection legislation** which is designed to ensure that all parties have the opportunity to defend their behaviour against accepted legal principles.
6. COPS concludes that **the consultation paper has not established a causal link** between the non-affordability of private medical specialist care for some Australians and the provision of specialist services for which the fees are described in these papers as "excessive".
7. Should examination of the data reveal that medical or non-medical practices with fees at the higher end of the distribution are treating patients with greater complexity or requiring highly specialised expertise and treatment, then **any intervention creating disincentives to the provision of these medical services may impact adversely on those patients**.
8. Labelling fees charged by medical specialists as excessive without appropriate peer review of the circumstances **runs the very high risk of commercial and professional defamation** of individual practitioners or groups of practitioners who have not had the opportunity to explain their billing practices.
9. COPS maintains that **none of the proposed interventions outlined in the consultation paper will have any beneficial impact** on the small proportion of Australians who are delaying essential medical care because of real lack of affordability. **These patients would instead benefit from an expansion of public hospital outpatient clinic services utilising the skills of our procedural specialists.**
10. The Council of Procedural Specialists will work with state and federal governments on policies which support and enhance the contribution of Australian medical specialists to the greater welfare of all Australians.

Recommendations

1. **Conduct further and more detailed peer review analysis** of fees currently considered to be outliers to determine the specific circumstances that may have produced this variation.
2. **Remove restrictions on the publication by medical associations of indicative fee schedules** to inform patients of the range of fees being charged in any particular medical specialty, enhancing the ability of patients to use AI to make more informed choices.
3. **Exempt medical practitioners from prosecution by the ACCC if they discuss fees** at meetings of registered medical associations.
4. **Work with medical colleges to develop more standardised informed financial consent methodologies** within the CPMC ethical framework**.**
5. **Use existing state and territory consumer protection legislation** to regulate specific occurrences of exploitative business practices by any health professional.



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Chair, Council of Procedural Specialists



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--- END OF SUBMISSION ---

APPENDIX

Table 1: ABS Survey of Australians who delayed medical specialist care due to cost

Survey Year	Verified ABS Figure
2009	9.7%
2010/11	11.9%
2011/12 *	8.4%
2012/13	7.8%
2013/14	7.9%
2014/15	8.1%
2015/16	8.1%
2016/17	7.3%
2017/18	7.9%
2018/19	7.7%
2019/20	8.0%
2020/21	5.9%
2021/22	8.0%
2022/23	10.5%
2023/24	9.8%
2024/25	8.6%

*Change in methodology