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RACP Submission: Specialist Affordability - Options to address excessive fee charging

Department of Health, Disability and Ageing
October 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,600 physicians and 9,700 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

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We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to respond to the Department of Health, Disability and Ageing's consultation paper [Specialist Affordability: Options to address excessive fee charging](#).

The RACP recognises that, although most medical practitioners set fees responsibly, a small minority are charging excessive out-of-pocket costs that can directly affect patients' ability to access care.

Genuinely excessive charging should be addressed, noting that excessive fees are only one small component of the affordability challenge. Action on excessive fees will need to be accompanied by measures to expand public outpatient capacity, reduce waiting times, improve the adequacy of Medicare rebates and improve access to specialists in underserved communities.

The RACP supports action on genuinely excessive fees and recommends a staged approach. In the first stage, this means sharing item-level, specialty-specific data, implementing and evaluating the informed financial consent, transparency and education reforms already under way, giving providers a formal opportunity to justify a flagged fee, and placing accountability on the billing entity where fees are set organisationally.

Stronger measures in a second stage, such as caps, should be considered only if clear evidence shows they would reduce excessive fees without harming access.

The RACP does not endorse any single definition of "excessive" fee, benchmark or regulatory model presented in the consultation paper as they **do not adequately reflect the complexity of specialist care and fee charging**, for the following reasons:

- **A numerical outlier is not necessarily an inappropriate fee.** Clinical complexity, time, case mix, risk, geography, practice costs and models of care can all produce legitimate variation.
- **The MBS Schedule Fee is a poor proxy for the contemporary cost or value of care.** It is the basis for a patient rebate, not a measure of what a service costs to deliver, and its real value has eroded.
- **The data are not yet granular enough** for us to understand what is driving apparent outliers. Item-level, specialty-specific data must be shared and further analysed before conclusions are drawn.
- **Getting the benchmark wrong could cause harm.** Blunt thresholds risk misclassifying legitimate variation and influencing provider behaviour: fee convergence, reduced bulk billing, costs shifting elsewhere, and specialists reconsidering participation in Medicare or in particular services or locations.

Recommendations

The RACP recommends that the Department and Government:

1. **Undertake further work to understand what constitutes a genuinely excessive fee before any definition is applied or threshold set.** This work should be done in close collaboration with medical colleges, the Council of Presidents of Medical Colleges (CPMC) and specialty societies; draw on item-level, specialty-specific data, and account for the complexity and diversity of specialties and models of care.

2. **Ground any resulting definition in reasonableness.** Statistical measures should be used only to identify fees for review. They should draw on multiple indicators and should not lead to a provider being classified as charging excessive fees until specialty-specific context has been considered. The MBS Schedule Fee, or a uniform multiple of it, should not be used as a standalone benchmark.
3. **Give time to transparency, informed financial consent (IFC) and education reforms to be rolled out and assessed.** The *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026* should be given the opportunity to be implemented and assessed before further regulatory changes are considered. Nationally consistent education on IFC approaches should also be prioritised before regulation is considered.
4. **Not consider stronger measures, such as fee caps,** until the effect of the above reforms is understood and clear evidence that stronger measures would reduce excessive fees without harming access is established.
5. **Give providers a formal opportunity to justify a fee** before any consequence and ensure that if peer assessment is pursued, it be profession-informed, confidential and timely.
6. **Ensure no patient loses a Medicare benefit** because of a provider's billing.
7. **Place any accountability regarding fees on the billing entity as well as the individual practitioner,** where fees are set organisationally.
8. **Apply an explicit Aboriginal and Torres Strait Islander health equity assessment to every option,** with co-design and Indigenous-specific monitoring.

RACP position on fees and professional standards

Although most medical practitioners set fees responsibly, the RACP acknowledges that a small minority are charging excessive out-of-pocket costs which can directly affect patients' ability to access care.

The RACP has no role in setting or recommending fees charged by its members.

Medical practitioners are free to set their own fees reflecting a range of complex clinical, professional and practice-related considerations. Nonetheless, **the RACP supports responsible billing practices and stresses that all medical practitioners have an ethical duty to establish reasonable fees** that reflect their expertise, practice expenses and patient circumstances. Fees should generally align with community and professional standards of fairness and reasonableness.

The RACP fully supports informed financial consent (IFC) and welcomes increased transparency of physician fees, as set out in detail in [our recent submission](#) to the Australian Senate inquiry into the Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026 and [our submission](#) to the Department in response to its consultation paper on fee transparency, informed financial consent and split billing practices.

The recently published [CPMC Framework on Ethical Billing and Fee Transparency](#) which the RACP contributed to, consolidates the expectations already embedded in medical colleges' codes: **fees should be fair, reasonable, proportionate and justifiable.** They must not exploit a patient's vulnerability or limited alternatives, hidden or unexplained booking and administrative fees are unacceptable, and compassionate billing should be offered to priority populations. **The RACP and other medical colleges are committed to supporting these expectations.**

Whilst the consultation paper observes that existing professional frameworks have not prevented excessive fees, the CPMC Framework is new and its impact on the profession

along with the Government's implementation of the [Health Legislation Amendment \(Improving Choice and Transparency for Private Health Consumers\) Bill 2026](#) cannot yet be assessed. Evaluating the impact of these measures will help determine whether further policy interventions are necessary and ensure any future changes are targeted, proportionate and responsive to identified gaps. **Introducing additional regulatory obligations or interventions before the impact of existing measures is fully understood may increase complexity for medical practitioners and health services**, particularly while systems and responsibilities across patients, medical practitioners and organisations continue to evolve.

Legitimate variation in specialist practice is an important consideration

Specialist practice is complex. Clinical complexity, time, expertise, case mix, risk, location, practice costs and different models of care all matter, and the same MBS item can encompass substantially different procedures, time and complexity. The consultation paper itself recognises this in its colonoscopy example and the examples below from RACP specialties further illustrate this point.

Examples from RACP specialties that illustrate the variety and complexity of specialist practice:

Nuclear medicine: Radiopharmaceutical costs are not funded separately from the MBS fee and are expected to be absorbed within it. The 2012 MBS funding review¹ and the 2018 MBS Review Taskforce² both found that Schedule fees do not reflect these costs, and that for some items the tracer costs more than the fee. Costs also include capital equipment (gamma cameras, SPECT/CT and PET/CT), short half-life tracer supply and radiation safety compliance.

A single study can involve several MBS items, so item-level analysis, and billing software that attributes out-of-pocket costs to one item, risk false positives.

Fees in private imaging groups are often set by the entity rather than the physician. As a small specialty, nuclear medicine produces median and percentile thresholds that are unstable and can be driven by a few large entities.

Nephrology: Nephrology, like many other physician specialties (e.g. geriatric medicine, rheumatology, endocrinology, infectious diseases, neurology, paediatrics, etc), is a predominantly cognitive, non-procedural specialty. It is centred on the long-term management of chronic kidney disease, dialysis and transplantation.

Care often involves patients with multiple comorbidities (such as diabetes, cardiovascular disease and complex polypharmacy) over many years, and consultation length and complexity are not well captured by MBS item descriptors.

Costs for multidisciplinary coordination (dietetics, nursing, pharmacy and psychology), remote monitoring for home dialysis and telehealth to regional patients are not reflected in Schedule fees.

Most dialysis and transplant follow-up is delivered in public and community settings at low or no cost to patients, so benchmarking from MBS data alone may misrepresent the specialty. With workforce shortages in regional and rural areas, blunt caps could reduce bulk billing for complex patients and encourage withdrawal from private practice.

¹ Department of Health and Ageing (2012), *Review of Funding for Diagnostic Imaging Services: Final Report*, Medical Benefits Reviews Task Group, Australian Government, February 2012.

² Medicare Benefits Schedule Review Taskforce (2018), *Final Report on the MBS Items for Nuclear Medicine*, Australian Government Department of Health

Paediatrics: Over time, paediatric practice has shifted from predominantly acute presentations to the long-term management of neurodevelopmental, behavioural, mental health and chronic conditions, including ADHD, autism spectrum disorder and trauma-related difficulties. Initial and follow-up appointments often run 60 to 90 minutes, and much of the work falls outside the consultation: caregiver-only sessions, medication titration and monitoring, liaison with general practitioners (GPs), allied health professionals and schools, and reports for early intervention and the NDIS. The Schedule fees do not recognise much of this work. Items restrict the number of claims regardless of clinical need, do not provide for caregiver-only consultations, and offer case conferencing that is focused on hospital discharge. In rural and regional areas, public waitlists frequently exceed two years, leaving private care as the only viable option. In addition, children in bulk-billing practices are less likely to be referred to specialists despite higher levels of developmental and behavioural concern.³ Benchmarks based on the Schedule fee could therefore label as excessive fees that reflect unfunded time and could reduce the viability of paediatric practice outside metropolitan centres.

The RACP accepts that clinical complexity does not explain all variation. One study cited in the consultation paper found patient characteristics explain only 4-6% of fee variability, and that very large spikes at the tail end of some item distributions are unlikely to reflect complexity.⁴ However, this does not in itself establish that the remaining variation is inappropriate or unexplained. It highlights the **need for more granular, item- and specialty-level analysis, alongside consideration of the clinical and practice context**, before conclusions are drawn from aggregate data.

Identifying and addressing "excessive fees"

The principle of reasonableness in identifying "excessive fees" should be further developed

Reasonableness is the approach most consistent with the CPMC Framework developed and endorsed by medical colleges. It recognises that fees should reflect factors such as time, clinical complexity, expertise, practice costs and prevailing benchmarks, and should be reasonable in relation to the service provided.

The RACP acknowledges the Department's concern that "reasonableness" requires further clarification in practice and notes this could be addressed through published criteria and specialty-specific guidance developed in consultation with medical colleges, CPMC and specialty societies.

Reliance on a single benchmark to determine "excessive fees" is not appropriate

The RACP does not support MBS Schedule fees being used as a benchmark for determining whether a fee is excessive as its real value has been eroded over time through inadequate indexation and the fee freeze. In addition, **some item descriptors no longer reflect contemporary clinical practice, complexity or the resources required to deliver the service.** The consultation paper's own analysis demonstrates that applying a uniform multiple to Schedule fees can have very different effects across items and specialties. Further,

³Hiscock H et al. (2025), Paediatric care in general practice: case mix, referral patterns and healthcare costs, Australian Journal of General Practice 54(6).

⁴Yong J et al. (2024), cited in section 5.3 of the consultation paper. The study examined in-hospital services using insurance claims data.

where an item is predominantly bulk billed, the median fee may converge with the Schedule fee, limiting the usefulness of the Schedule fee as an independent benchmark of whether a fee is reasonable.

The RACP does not support reliance on a single benchmark to determine excessive fees. Any assessment should draw on multiple indicators and allow for specialty-specific clinical and practice context. The approach should be developed in close consultation with medical colleges, the CPMC and the relevant specialty societies, so that it is practical, transparent and reflects the factors that influence fees across different settings and specialties. In any case, given that identifying an outlier does not in itself show that a fee is inappropriate, providers should have a clear opportunity to explain the circumstances and clinical factors behind a flagged fee before any conclusion or consequence follows.

Any measure to address excessive fees should be targeted, proportionate and staged, with its effects on patients, fee levels, bulk billing and specialist availability monitored and evaluated. Any consequence for a provider found to be charging excessive fees should fall on the provider, not on the patient, who has little practical ability to switch provider and should not lose a Medicare benefit because of how a provider bills.

Caps on individual MBS items are not supported

The RACP has serious concerns about caps on individual MBS items. The Department's analysis identifies price signalling, provider exit from Medicare, and disadvantage to complex care as risks. Clear and strong evidence would be needed to identify that caps can distinguish excessive charging from legitimate variation across specialties and models of care, and that these risks can be avoided, before being considered.

Incentives for lower out-of-pocket fees require further consideration

The RACP supports exploring incentives for lower out-of-pocket fees further noting that the consultation paper highlights practice-incentive-style payments are unlikely to be high enough to deter excessive charging and that matching the GP bulk billing incentive for specialists would require significantly more investment.

Further work is needed to understand whether incentives would improve affordability over the longer term, how they would influence clinical and business behaviour, whether they could create inequities between practices or regions, and what would happen if temporary incentives were later changed or withdrawn.

Incentives may be better suited to improving access for patients who have little practical ability to shop around or switch providers, such as those living in rural and remote areas, those with chronic conditions requiring ongoing specialist care, and those who cannot afford private care and face long public waiting times. For example, targeted incentives for bulk-billed, no-gap or low-gap specialist care delivered through, or in partnership with, Aboriginal Community Controlled Health Organisations (ACCHOs) could make specialist care more affordable for Aboriginal and Torres Strait Islander people.

Additional risks to consider when addressing "excessive fees"

Below are some additional risks the RACP recommends the Department and Government consider when addressing "excessive fees":

- **Access and workforce.** Poorly targeted regulation could accelerate reductions in private consulting hours, withdrawal from Medicare, or relocation away from regional and rural areas where private practice already supports limited public services. Small specialties with fragile workforces are most exposed.

- **Training capacity.** Whilst many trainees are supervised and upskilled in public settings, there are trainees who are supervised and upskilled in private settings. Reduced viability of private practice could constrain training placements and worsen future medical workforce shortages.
- **Disincentives to complex care.** A focus on fees above average may discourage practitioners from taking on the most complex and time-intensive patients thereby increasing health inequity and access barriers for those most in need of specialist care.
- **Fee behaviour.** Beyond the paper's risks, fee convergence and unbundled or fragmented billing (separate administrative or booking fees) could make billing less transparent.
- **Models of care.** Fee mechanisms that ignore the costs of multidisciplinary coordination, telehealth and remote monitoring could inadvertently discourage investment in models that improve access for people with chronic disease.

Improving access to specialists for Aboriginal and Torres Strait Islander people

For Aboriginal and Torres Strait Islander people, specialist affordability is not only a pricing issue. It is a question of health equity and equitable access to clinically necessary care.

The CPMC Framework recognises a duty to adjust or modify fees, or refer to an alternative provider, where cost would otherwise prevent necessary care, with particular attention to Aboriginal and Torres Strait Islander people and rural and regional patients.

The RACP recommends that the Department and Government:

- Apply an explicit **Aboriginal and Torres Strait Islander health equity assessment** to all options, covering access, affordability, continuity of care and specialist availability, and **co-design** reforms with Aboriginal and Torres Strait Islander people and the ACCHO sector
- Consider introducing **targeted incentives for bulk-billed, no-gap or low-gap specialist care**, including through or in partnership with ACCHOs and outreach models, and strengthen referral pathways between ACCHOs and affordable specialist services
- **Monitor for reductions in specialist availability** in rural, regional and remote communities after any cap, threshold or other intervention
- Establish **routine Indigenous-specific reporting** of utilisation, bulk-billing and no-gap rates, average and extreme out-of-pocket costs, delayed or forgone care and cumulative cost, and evaluate reforms on **equitable access**, not only on fee reductions.

Affordability is much broader than excessive fees

The Department's data show out-of-pocket costs have risen across the specialist market, not only at the extremes. This trend cannot be explained solely by a small minority of outliers. The primary drivers are system-level and extend beyond the control of individual physicians:

- **MBS rebates have not kept pace with inflation or the true cost of care.** Inadequate indexation and, for several years, a freeze have considerably reduced the real value of rebates. This gap is a fundamental driver of rising out-of-pocket costs.
- **Practice expenses are rising**, including wages, rent, utilities, insurance and equipment.
- **Workforce shortages and maldistribution** constrain meaningful patient choice. There are significant care deserts because there is no national coordination of specialist training to ensure a pathway for doctors to where they are needed.

- **Public outpatient capacity is inadequate**, so patients who cannot afford private care cannot readily access specialist care publicly.

The consultation paper recognises **high fees are sustained where demand is inelastic and public alternatives are constrained. The RACP agrees**, and notes that this means workforce and public capacity reform is part of the solution to excessive fees as well as to affordability more broadly.

Although the consultation paper places these issues out of scope, the RACP considers it important to highlight them and to note that they will be explored further through the [House Standing Committee on Health, Aged Care and Disability's inquiry into access to and affordability of medical specialists](#), to which the RACP is contributing.

The RACP calls on all levels of government to take coordinated action on the following broader reforms to improve the affordability and access to specialists:

- **Review Medicare items** to better reflect the realities, complexities and true costs of delivering care, including cost-reflective indexation and targeted re-basing where fees do not cover cost (such as radiopharmaceuticals), or separate funding of pass-through costs
- **Strengthen workforce planning and training** to match community need, by supporting the Health Workforce Taskforce to continue physician workforce modelling with RACP support, re-establishing a national body to coordinate health workforce planning, and investing in a real-time physician workforce data system
- **Expand public outpatient capacity** and specialist workforce planning to address access inequities
- **Fund bulk-billed specialist care clinics in ACCHOs** and develop collaborative care models with GPs and other healthcare practitioners.

Closing comment

The RACP:

- Is pleased to contribute to this important consultation and thanks the Department for seeking stakeholder input.
- Supports action against genuinely excessive fees but are not yet satisfied that any of the options presented would improve rather than inadvertently worsen access and affordability for patients.
- Supports the staged approach set out in our submission, beginning with data, transparency and a fair review process.
- Looks forward to working collaboratively with the Department, other medical colleges and the CPMC to jointly develop evidence-informed approaches and progress the broader reforms needed so that all Australians, no matter where they live, can get the specialist care they need without unfair financial barriers.

If you require further information or would like to engage with us, please contact Claire Celia, Senior Policy and Advocacy Officer, via the RACP Policy and Advocacy unit at Policy@racp.edu.au.