



Australian and New Zealand Association of Urological Surgeons

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19 October 2026

Medicare Benefits and Digital Health Division
Department of Health, Disability and Ageing

By email: specialistaffordability@health.gov.au

Dear Sir or Madam,

Re: Specialist Affordability: Options to address excessive fee charging

On behalf of the Australian and New Zealand Association of Urological Surgeons Inc. (ANZAUS), I am pleased to provide the following submission in response to the Department's consultation paper.

1. Summary

ANZAUS represents urologists across Australia and shares the Government's objective of ensuring that patients have transparent, fair and affordable access to specialist care. ANZAUS does not condone egregious fees, nor practices such as quoting a patient a substantially higher fee because they do not hold private health insurance, as described in the paper (1). Herein, ANZAUS addresses the Australian specialist funding and billing environment.

ANZAUS welcomes the paper's candid acknowledgement that fee variation can reflect clinical complexity, time, input costs, practice setting, private health gap arrangements and billing processes (1). ANZAUS supports a combination of approaches to defining an excessive fee: a market median calculated at a sufficiently granular level, followed where necessary by a peer-reviewed assessment of reasonableness by appropriate peers. ANZAUS's principal concern is that the limitations acknowledged in the paper are not yet resolved in the proposed definitions, and that out-of-pocket growth also reflects the declining real value of Medicare and insurer benefits. While a discussion of broader healthcare affordability is not within the scope of the consultation paper, it is nonetheless essential to discuss these issues, as they are contributing factors to the problem. To assist the Department, ANZAUS sets out the measures it would support for identifying and addressing genuinely excessive fees fairly (Section 7), and would welcome the opportunity to work with the Department on their design (1–3).

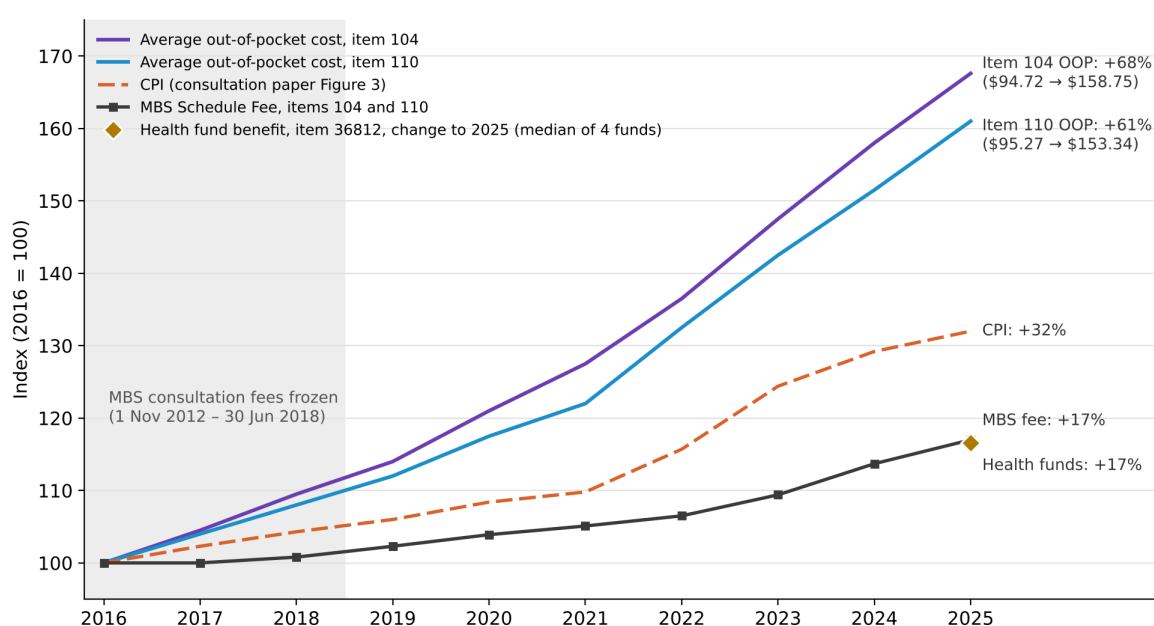
2. Rising out-of-pocket costs require a more complete explanation

Although private health insurance arrangements are formally outside the scope of the paper, ANZAUS considers that a discussion of Medicare and health fund rebates is essential here, as the two issues cannot be decoupled. Out-of-pocket costs are a central tenet of the paper's argument, and they are determined as much by the benefits paid as by the fees charged. Over the last decade, health fund benefits for common urological procedures have increased by as little as approximately 4% and at most approximately 17%, while CPI has increased by approximately 30% (Section 5). Each year that insurer schedules fail to match inflation produces a real saving for insurers at the expense of patients and practitioners. ANZAUS urges the Department to give this issue priority (3,4).

The paper is correct to identify rising patient out-of-pocket costs as a serious concern (1). However, out-of-pocket cost is a residual amount: the difference between the fee charged and the benefits paid. Its growth therefore reflects not only provider fees but also the real value of Medicare benefits, insurer medical-gap schedules, known-gap thresholds, service mix, utilisation and population growth. The paper notes that its headline aggregate out-of-pocket figures are not CPI-adjusted, and as totals they also include growth in population and service volume (1).

For items 104 and 110, the Schedule Fees were unchanged from 1 November 2012 until 30 June 2018 and have since increased at rates below CPI. Between 2016 and 1 July 2026, the Schedule Fees for both items increased by only 21.5% (item 104 from \$85.55 to \$103.95), while CPI rose by 35.6% between June 2016 and June 2026, a real reduction of about 10.4% (2,3). Figure 1 places the Department's out-of-pocket series alongside CPI, the MBS Schedule Fee and health fund benefits.

Figure 1. Out-of-pocket costs, CPI, MBS Schedule Fee and health fund benefits, 2016–2025



Note: Out-of-pocket and CPI series as published in the paper's Figure 3, with exact out-of-pocket endpoints (1). MBS Schedule Fees are calendar-year time-weighted averages (2). The health fund marker is the median change in the benefit for cystoscopy (item 36812) across the four funds and periods shown in Table 3 (4). A procedure item is shown because urology is a procedural specialty, and procedural items are where most urological billing occurs.

Using the Department's own Figure 3 endpoints, the rise in out-of-pocket costs above CPI can be separated, on an accounting basis, into fee growth above CPI and Medicare benefit growth below CPI (Table 1).

Table 1. Decomposition of above-CPI growth in average out-of-pocket costs, items 104 and 110

Measure, 2016 to 2025	Item 104	Item 110
Average out-of-pocket cost, 2016 → 2025	\$94.72 → \$158.75	\$95.27 → \$153.34
Growth in out-of-pocket cost	+67.6%	+61.0%
Derived average fee charged	\$167.47 → \$243.90	\$223.57 → \$303.47
Growth in derived average fee charged	+45.6%	+35.7%
Growth in Medicare benefit	+17.0%	+17.0%
Out-of-pocket increase above CPI	\$33.72	\$27.58
Due to Medicare benefit lagging CPI	\$10.88 (32%)	\$19.23 (70%)
Due to fee growth above CPI	\$22.84 (68%)	\$8.35 (30%)

Note: Accounting decomposition of the above-CPI increase in average out-of-pocket cost for patient-billed services, using the paper's published endpoint values and its stated CPI growth of 32% over the same period (1). Derived average fee = Medicare benefit + out-of-pocket. Above-CPI increase = 2025 out-of-pocket – (2016 out-of-pocket × 1.32). As the paper's out-of-pocket figures are net of Extended Medicare Safety Net benefits, derived fees may be slightly understated.

Table 1 shows that a material share of the increase is associated with benefit erosion, particularly for item 110. Percentages should, however, be interpreted with care in this context. The Schedule Fee for item 104 (\$103.95) is substantially lower than that for item 110 (\$183.35), so the same dollar movement represents a larger percentage for item 104. In real dollar terms, fee growth above CPI for item 104 amounts to \$22.84 over nine years, or about \$2.50 a year, and across both items the Medicare benefit shortfall (\$30.11) is of a similar magnitude to fee growth above CPI (\$31.19) (2). Fee growth above CPI is not of itself evidence of excess, as the principal costs of specialist practice, including staff wages, medical indemnity, rent and compliance, are not measured by CPI. ANZAUS therefore suggests that out-of-pocket growth be analysed alongside rebate erosion and practice costs before it is treated as a proxy for excessive charging.

ANZAUS also notes two points the Department may wish to clarify. Figure 3's endpoint labels read "2026", although the series ends in 2025. In addition, the 72.2% increase in in-hospital gap payments is described as occurring over 2019 to 2025, yet the cited footnote refers to "HCP1 data 2014 to 2019" (1).

3. Defining an excessive fee

ANZAUS agrees with the paper that there is no agreed definition of excessive fee charging and that each of the three approaches has practical limitations (1). The choice of benchmark materially alters the result: in 2025, 1.1% of in-hospital services were charged at three to five times the median fee, compared with 3.9% when measured against the MBS Schedule Fee (1).

Reasonableness

ANZAUS considers a reasonableness test to be a valid option, though not necessarily the best, as peer comparison is also a credible option. A reasonableness test has the advantage of taking account of the service actually delivered, including time, complexity, input costs and circumstances. Its

success will depend on how those factors are measured and weighted, who makes the assessment and what review rights apply. ANZAUS is concerned, however, by the Support at Home model cited as a precedent, under which the price charged must not be "unreasonable", a term that is not further defined, and the regulator may order refunds, issue compliance notices and take enforcement action, including varying a provider's registration (1,5). ANZAUS would encourage a reasonableness framework built on criteria developed with the profession. ANZAUS is particularly concerned by the overt emphasis on enforcement action and harsh penalties, which seems excessively punitive.

Peer comparison and the market median

ANZAUS shares the paper's caution that deviation from the median does not establish whether the median itself is reasonable. The fee distributions include bulk-billed services, and Appendix A notes that "this impact of removing bulk billed services has not been assessed in this paper" (1). Comparisons are also made at the Derived Major Specialty (DMS-2) level, so that subspecialists undertaking complex tertiary work are benchmarked against all urologists billing the same item. For example, item 36522 (partial nephrectomy) does not distinguish a relatively straightforward partial nephrectomy for a small lower-pole kidney tumour in a fit patient with two kidneys and normal renal function from a highly complex partial nephrectomy for a central tumour adjacent to the major renal vessels and critical structures in a patient with multiple comorbidities, renal impairment and a solitary kidney (2). The latter is most likely to be undertaken by a subspecialist in a tertiary centre, while the former may be undertaken by a general urologist. Yet the complex case requires significantly more training and expertise, and carries far greater risk: in a patient with a solitary kidney, a major complication could mean lifelong dialysis.

ANZAUS also submits that markets need to be considered at a granular level, as there are sub-markets within markets, and it is not reasonable to use a national median. At a minimum, medians should be calculated at state level and should separate metropolitan from provincial practice, as metropolitan practitioners generally carry significantly higher costs. Costs also vary considerably between metropolitan centres. For example, in the March quarter of 2026, average prime net face office rents were \$1,443 per square metre per annum in the Sydney CBD, compared with \$572 in the Adelaide CBD (6). Central Sydney and Adelaide or Hobart are all metropolitan, yet their cost structures are not comparable. Rent, staffing, theatre availability, travel and equipment logistics vary in the same way.

ANZAUS's preferred approach is therefore a combination of the two methods: a market median, calculated at a sufficiently granular level to reflect each market and sub-market, as the initial screen, followed where necessary by a peer-reviewed assessment of reasonableness by appropriate peers. The measures in Section 7 reflect this approach.

The MBS Schedule Fee

The paper rightly acknowledges that the Schedule Fee may not reflect costs. Indeed, the Schedule Fee was never a cost-based schedule: it originated in the "most common fees" charged when the schedule began, and the Relative Value Study that sought to link fees to costs was never implemented (7). Appendix B also states that "MBS benefits are not a provider benefit, nor are they intended to cover the full cost of a service" (1). As the Schedule Fee has also fallen in real terms, a multiple of it would be a benchmark that tightens every year (2,3). **For these reasons, ANZAUS opposes any definition of an excessive fee that is linked to the MBS Schedule Fee.** Over time, such a link would make private practice progressively unsustainable as costs outstrip revenue, encourage practitioners to leave the private sector and reduce the capacity to deliver specialist services across

the country.

The paper draws on the Grattan Institute's definition of three times the Schedule Fee (1,8). The Grattan model would withdraw all Medicare funding from specialists whose fees average more than three times the Schedule Fee (8). ANZAUS does not support the Grattan model, for the reasons set out above in relation to the Schedule Fee. ANZAUS does, however, welcome the same report's recommendation that Medicare rebates be reviewed to ensure they reflect the actual cost of care (8).

The evidence base

The paper does not yet present practice-cost evidence alongside its fee analysis, nor quantify the "small minority" of providers said to charge excessive fees, and its fee distributions cover a single year (2025) (1). ANZAUS would be pleased to assist the Department in building that evidence base for urology.

4. Procedural billing and item-level analysis

ANZAUS welcomes the paper's recognition that fair labelling of a fee requires accurate data and correct assignment of out-of-pocket costs to the right MBS item (1). This is particularly important for procedural specialties. Appendix A states that "all analysis in this paper is conducted at the MBS item level and does not account for the interaction of the Multiple Operation Rule, modifiers, or use of deposits by providers" (1). Urological procedures are routinely billed across several items, so item-level figures may not reflect the episode of care.

For example, consider ureteroscopy and laser lithotripsy (item 36809, Schedule Fee \$997.15) with removal and replacement of a ureteric stent (item 36823, Schedule Fee \$635.20). Under the multiple operation rule, the combined rebate-relevant fee is \$1,314.75. For an illustrative total fee of \$3,500, the same total can appear either below or above a three-times-Schedule-Fee threshold depending only on how the account is allocated across items (Table 2).

Table 2. Effect of fee allocation across co-claimed items on apparent fee multiples

Billing method	Fee on 36809	Fee on 36823	36809 as multiple of Schedule Fee	Patient out-of-pocket
Split in proportion	\$2,654.65	\$845.35	2.66×	\$2,185.25
Gap placed on main item	\$3,182.40	\$317.60	3.19×	\$2,185.25

Note: Schedule Fees as at 1 July 2026 (2). Patient out-of-pocket cost assumes Medicare (75%) and insurer minimum (25%) benefits on the multiple operation rule fee of \$1,314.75, outside any gap-cover arrangement. Under a gap-cover arrangement the out-of-pocket cost would be lower, but it would remain identical in both cases.

The procedure, total fee and patient out-of-pocket cost are identical in both cases, yet only the second appears to cross the threshold. The paper also cites research attributing most fee variation to specialist-specific factors (1). Such variation will necessarily include legitimate differences in training, service model, staffing and practice costs, as well as these allocation effects. ANZAUS therefore suggests that statistical thresholds be used only as a screening signal, and that procedural fees be assessed at the level of the episode of care.

5. Private health insurance settings

The paper recognises that in-hospital fees interact with Medicare and insurer benefits, and that

insurers determine the benefits payable under no-gap and known-gap arrangements (1). For common urological procedures, insurer gap-cover benefits have consistently failed to keep pace with CPI and have largely tracked MBS indexation, with some funds lagging further behind (Table 3). Patient affordability can therefore worsen even where provider fees only keep pace with inflation (2–4,9,10).

Table 3. Change in MBS and insurer gap-cover benefits for common urological procedures

Fund / scheme	Period	Benefit	Change	CPI same period	Real change
Cystoscopy (item 36812)					
MBS Schedule Fee	Jul 2016 – Jul 2025	\$166.70 → \$194.45	+16.6%	+30.5%	–10.6%
Medibank GapCover	May 2017 – Jul 2025	\$252.95 → \$295.05	+16.6%	+28.3%	–9.1%
Bupa known gap	Jan 2016 – Mar 2025	\$270.60 → \$281.30	+4.0%	+28.6%	–19.2%
HCF Medcover known gap	Dec 2016 – Jul 2026	\$253.40 → \$295.25	+16.5%	+34.7%	–13.5%
nib MediGap	Jul 2016 – Jul 2025	\$254.65 → \$296.95	+16.6%	+30.5%	–10.6%
Transurethral resection of the prostate (item 37203)					
MBS Schedule Fee	Jul 2016 – Jul 2025	\$1,042.15 → \$1,215.70	+16.7%	+30.5%	–10.6%
Medibank GapCover	May 2017 – Jul 2025	\$1,581.75 → \$1,845.15	+16.7%	+28.3%	–9.1%
Bupa known gap	Jan 2016 – Mar 2025	\$1,693.65 → \$1,759.25	+3.9%	+28.6%	–19.2%
HCF Medcover known gap	Dec 2016 – Jul 2026	\$1,584.05 → \$1,846.00	+16.5%	+34.7%	–13.5%
nib MediGap	Jul 2016 – Jul 2025	\$1,591.85 → \$1,856.95	+16.7%	+30.5%	–10.6%

Note: Benefit amounts from published MBS and insurer schedules (2,4,9,10). CPI is measured between the last complete quarters before each schedule date shown, and real change is calculated for each period on that basis (3).

Over these periods, insurer benefits increased by approximately 4% to 17%, while CPI increased by approximately 28% to 35%. Each year that insurer schedules do not match inflation produces a real saving for insurers, at the expense of patients and practitioners. Known-gap allowances have followed the same pattern. Applying the 35.6% CPI increase between June 2016 and June 2026, a \$500 known-gap allowance in place in 2016 would need to be about \$678 today, a real loss of about 26% (3). As the same nominal allowance applies to both short and long, complex procedures,

complex surgery is increasingly pushed outside known-gap arrangements, where patients' out-of-pocket exposure can rise sharply (9,10). Until 1 October 2024, nib's MediGap scheme permitted no-gap billing only, with no known-gap option (10). The AMA has also reported that private health insurer benefits paid in total for in-hospital medical treatment increased by 18.1% over the six years to June 2025, while insurer profits increased by 49.4% (11).

ANZAUS therefore recommends that health fund benefit schedules be decoupled from the MBS Schedule Fee, and that funds be encouraged to index their schedules and known-gap allowances to inflation. ANZAUS acknowledges that budgetary pressures may constrain the Government's ability to index the MBS in line with inflation. The same constraint should not apply to health funds, whose benefits are funded from member premiums that are themselves increased each year.

6. Response to the proposed interventions

Fee transparency and patient empowerment

ANZAUS understands fee transparency as an option, and supports informed financial consent. To be meaningful, any transparency measure, if introduced, should also allow clinicians to differentiate their service. Clinicians vary in their training, expertise, staffing and support, and service offering. There needs to be scope for clinicians to explain, and for patients to see, why one clinician charges more than another. ANZAUS does not, however, support a mandatory obligation for practitioners to publish their differentiating factors on a Government-controlled website. Rather, patients should be encouraged to seek an explanation where a fee appears to be at an excessive level. This would be relevant only to the small minority of practitioners who charge well in excess of their peers.

Two models illustrate the point. Under the Department's own Support at Home program, the Government publishes the median and range of prices for each service type, providers must publish the price they most often charge and report their prices to the Department, and providers must explain in the service agreement any difference between the agreed price and the published price (1,5). Similarly, hotel booking sites show price alongside star rating, facilities and location; a list showing price alone would mislead consumers, as it would for almost any other service. The paper identifies information asymmetry between patients and providers as a driver of fee variation (1). ANZAUS believes the most effective response is to give patients meaningful information about what they are paying for, rather than price in isolation.

ANZAUS does not support the public flagging of individual practitioners in any form. Wrongly labelling a practitioner as an excessive charger would represent a serious miscarriage of justice and cause lasting reputational harm. De-identified comparisons, such as the medians and ranges published under Support at Home, presented for given markets and sub-markets away from the individual level, would be preferable.

Provider education

ANZAUS supports confidential, educational letters as a proportionate first step, consistent with the paper's view that they may help test a chosen definition (1).

Peer assessment

ANZAUS supports peer assessment in principle, as it allows individual circumstances to be considered. However, its fairness will depend on the definition of a peer. A surgeon who is essentially a full-time salaried staff specialist in a public hospital, undertaking limited private practice without the need to run consulting rooms, is not a peer of a surgeon in full-time private practice who carries the full cost of that practice. The two models have fundamentally different cost structures, and the

fees sustainable for one are not a fair measure of the other. Peers should therefore have comparable practice models and costs.

Fee caps

ANZAUS does not support fee caps. Caps would rely on broad, generic data and could not account for the range of complexity, expertise, training, practice costs and service delivery that legitimately inform fees. They would also penalise specialists who charge some patients more so that they can bulk bill or reduce fees for those unable to pay and, as the paper notes, may lead to higher fees at the lower end, reduced bulk billing, caps acting as price targets and providers leaving Medicare (1). Withholding Medicare benefits would leave patients further out of pocket while the provider retains the fee, as the paper acknowledges (1). Caps would also discourage practitioners from remaining in private practice, which could overload the public sector and lead to the other unintended consequences outlined in Section 8. The most direct way to reduce out-of-pocket costs is not to cap fees, but to restore the real value of Medicare and insurer benefits.

Incentives, education and collaboration

Beyond restoring benefits, ANZAUS supports further consideration of incentives, and encourages the Department to rely on education and collaboration with the profession wherever possible, with punitive measures reserved as a last resort. An approach centred on penalties could affect the morale of the medical workforce and make medicine a less attractive career for capable young Australians.

7. Measures supported by ANZAUS

ANZAUS would support the following staged measures, which it believes would allow genuinely excessive fees to be addressed fairly and with the confidence of the profession:

1. **Screening.** Identify potential outliers using episode-level data that accounts for the multiple operation rule, modifiers and co-claims, against specialty-specific medians calculated at no broader than state level and separated by metropolitan and provincial practice. Only the most extreme outliers within each comparison group would be flagged.
2. **Verification.** Confirm data accuracy and item allocation with the provider before any further step.
3. **Education.** Send a confidential letter advising the provider of their position relative to appropriate peers, with an opportunity to respond.
4. **Peer review.** Refer persistent, unexplained outliers to a panel of specialty peers with comparable practice models, applying criteria developed with the relevant specialty society, with rights of reply and appeal.
5. **Proportionate response.** Consider further measures only where peer review finds a fee unreasonable and the pattern persists, without withholding patients' Medicare benefits.

In parallel, the real value of MBS rebates, insurer schedules and known-gap allowances should be restored, and transparency measures should allow clinicians to describe their service. ANZAUS would welcome the opportunity to help the Department develop and test these measures.

8. Responses to the consultation's open questions

Factors considered in setting fees. Fees reflect the service offering, including the experience, expertise, training and qualifications of the surgeon and the services of the practice, such as nurse practitioners, specialist nurses, consultation time and continuity of care. They also reflect practice

costs, the complexity and duration of the procedure or consultation. Fees may also be reduced or waived for patients experiencing hardship, and special circumstances are taken into account, including chronic health conditions and the need for repeated procedures, together with general compassion and understanding towards the patient and their individual and unique circumstances.

Implications for private health insurance. Insurer schedules and known-gap allowances that are not indexed to inflation reduce insurers' real costs each year and shift costs to patients (Section 5). Measures directed at specialist fees will be most effective if insurer benefit indexation is addressed at the same time, and ANZAUS strongly encourages the Department to address this issue.

Other risks and unintended consequences. Risks not discussed in the paper include the loss of practitioners from private practice, reduced service capacity and increased pressure on the public sector, effects on workforce morale and recruitment, comparison against inappropriate peers, and the progressive tightening of any benchmark linked to an under-indexed Schedule Fee. More broadly, measures that discourage private practice risk undermining the balance of public and private care that underpins Australia's strong results. In the Commonwealth Fund's Mirror, Mirror reports, Australia ranked first for health care outcomes in 2017, 2021 and 2024, and first overall in 2024 (12–14). Similarly, the Healthcare Access and Quality Index, derived from mortality from causes amenable to health care, ranked Australia equal fifth of 195 countries, with a score of 95.9, compared with 23rd for the United Kingdom (15). Australia also has one of the highest life expectancies in the OECD, ranked seventh of 38 member countries in 2023, and cancer survival among the highest internationally (16,17). By contrast, the United Kingdom's National Health Service, while ranked highly overall on measures such as affordability, equity and administrative efficiency, ranked 10th of 11 countries for health care outcomes in 2017, 9th of 11 in 2021 and 8th of 10 in 2024 (12–14). In February 2026, 7.2 million pathways were awaiting elective treatment in England, with only 62.6% waiting less than 18 weeks against a 92% standard (18). Weakening the private sector could affect the quality and timeliness of care in Australia.

Other policy options. Above all, the real value of MBS rebates should be restored. Years of under-indexation have shifted costs from the Government to patients, and restoring rebates is the single most effective measure available to reduce out-of-pocket costs across the board. In addition, insurer schedules and known-gap allowances should be indexed to CPI, benchmarks should be calculated at state and metropolitan or provincial level, and the measures in Section 7 should be adopted.

9. Recommendations

ANZAUS recommends that the Department:

1. Treat the limitations acknowledged in the paper as design constraints, and work with ANZAUS and other specialty societies to develop the measures set out in Section 7.
2. Publish, alongside out-of-pocket trends, the Schedule Fee, Medicare benefit, insurer benefit and average fee for the same items, in nominal and CPI-adjusted terms.
3. Give priority, in parallel with this work, to restoring the real value of the MBS schedule, and decouple health fund benefit schedules from the Schedule Fee so that funds index their schedules and known-gap allowances to inflation.
4. Not link any definition of an excessive fee to the MBS Schedule Fee.
5. Define an excessive fee using granular measures such as sub-market medians, built at episode level, specialty-specific, no broader than state level, separated by metropolitan and provincial practice, and excluding bulk-billed services. This initial screen could be followed, where necessary, by a peer-reviewed assessment of reasonableness.

6. Use statistical thresholds only as a screening signal, with verification and a right of reply, never as an automatic finding.
7. Develop any reasonableness test with the profession, with defined criteria, process, decision-maker and appeal rights, and without the punitive elements of the Support at Home model.
8. Define peers for any peer assessment as practitioners with comparable practice models and costs.
9. If fee transparency measures are introduced, ensure they allow clinicians to describe the factors that differentiate their care, such as level of training, staffing and support, consultation time and other differentiating factors, and do not publicly flag individual practitioners.
10. Not proceed with fee caps or the withholding of Medicare benefits, and reserve punitive measures as a last resort, relying wherever possible on incentives, education and collaboration.

10. Conclusion

ANZAUS shares the Department's commitment to affordable specialist care and agrees with many of the paper's cautions. A model that uses carefully constructed statistical screens to prompt verification, education and specialty-informed peer review would be workable and fair. ANZAUS would welcome the opportunity to work with the Department to develop it, alongside action on the indexation of Medicare and insurer benefits that underlies much of the affordability pressure the paper describes.

Thank you for the opportunity to contribute to this consultation. Please direct any enquiries regarding this submission to the Chairman of ANZAUS, A/Prof Troy Gianduzzo.

Yours sincerely,



A/Prof Troy R.J. Gianduzzo
MBBS, MPhil (UQ), MBA (UQ), AFRACMA, FRACS, FUSANZ
Chair, Australian and New Zealand Association of Urological Surgeons

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