Submission: Inquiry into access to and affordability of medical specialists in Australia

To:	House of Representatives Standing Committee on Health, Aged Care and Disability – Consultation on specialist affordability and access
From:	Australian Medical Association (SA) (AMA SA)
Date:	16 October 2026

Executive summary

This submission represents the position of the Australian Medical Association in South Australia (AMA SA) and particularly the AMA SA Council, which comprises medical practitioners from a range of specialties, metropolitan and regional locations, and career levels.

AMA SA welcomes the Australian Government's attention to specialist affordability. We accept that a small minority of specialists charge fees that their peers would regard as unreasonable, and patients deserve protection from them. We also note that excessive fees are one element of a broader affordability problem, not the entire problem.

Before discussing the consultation paper, we note that South Australia brings a particular perspective to discussion of the affordability of specialist care and access to healthcare more generally. It has the oldest population of any mainland state, with the second-highest share of people over 65 and the highest share over 85; 22% of its people live outside Adelaide with one private hospital between them; and its public system is under a fiscal restraint program that will shape specialist capacity for the rest of the decade. The consequences of getting this consultation wrong will be felt in South Australia first.

Our submission makes three arguments and offers 12 recommendations.

First, in South Australia, affordability is a capacity problem before it is a price problem. Where public specialist capacity is not adequate, those who can pay move to private care and those who cannot, wait – and the fee they cannot afford is not recorded. Meanwhile, South Australia already publishes public outpatient waiting times by specialty and hospital, and has done so since 2018. It is the only jurisdiction to do so on a quarterly basis. That data, and the planned-surgery data that follow it – a median wait that rose to 52 days in 2024-25 while the national median fell, with only 59% of urgent patients treated on time – show that the largest affordability lever available to government is public specialist capacity, and that a national outpatient waiting-time dataset built on the South Australian model is the single reform most likely to make the private fee problem measurable.

Second, the out-of-pocket cost to the patient is mostly due to the rebate gap. Over the decade to 2024-25, specialist fees rose 36% in real terms while Medicare benefits rose 14%; the share of the fee covered by Medicare fell from 65 to 55%. Policy that addresses the numerator without the denominator will not durably lower what patients pay. AMA SA supports action against genuinely excessive fees, and supports it more readily than the profession is sometimes credited with – provided it is targeted, defined transparently and paired with restoration of the rebate.

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Third, the design matters more than the instrument. Of the six options canvassed, AMA SA supports strengthened transparency and informed financial consent, targeted provider education, and peer assessment through an existing professional body; it does not support per-service fee caps. Consistent with the Federal AMA, we support a published statistical trigger for referral to review – a multiple of a properly constructed specialty peer distribution, combined with an absolute-dollar materiality test and averaged over a billing year – and we reject the Schedule Fee as the comparator until it is re-indexed to cost. A defined trigger is the profession's best protection against a blunt cap, and it isolates the outlier from the majority.

Recommendations at a glance

No.	Recommendation	Domain
R1	Establish a national specialist outpatient waiting-time dataset, modelled on the South Australian quarterly report and extended to referral date, triage category, first-appointment date and removals without treatment, by specialty, site and remoteness.	Access
R2	Treat public specialist outpatient and theatre capacity as the primary affordability lever and use the National Health Reform Agreement to fund and measure it.	Access / affordability
R3	Restore the value of the rebate: independent, transparent MBS indexation against a health-specific input cost index; mandatory insurer reporting of benefit levels relative to fees.	Affordability
R4	Define the trigger for review as a published multiple of a properly constructed specialty peer distribution (non-bulk-billed services, in-hospital and out-of-hospital separated, minimum volumes) combined with an absolute-dollar materiality test, averaged over a billing year rather than a multiple of the Schedule Fee, and as a trigger for review, not a cap.	Excessive fees
R5	Refer providers exceeding the trigger to peer assessment through an existing body with clinical membership and natural-justice protections; consequences to include patient remediation.	Excessive fees
R6	Do not introduce per-service fee caps. Monitor for price signalling and cross-subsidy effects under any intervention and publish the monitoring.	Excessive fees
R7	Strengthen the Medical Costs Finder with individual provider fees and insurer benefits, backed by a public education campaign, and evaluate before legislating further.	Transparency
R8	Retain informed financial consent as an ethical and professional obligation; apply any transparency obligation to all registered health practitioners; define ‘split billing’ precisely and reject lead-practitioner liability for other providers' fees.	Transparency
R9	Fund MBS items for GP-specialist advice (both parties), longer referral validity for stable chronic disease, and closed-loop referral feedback.	Access
R10	Introduce a targeted specialist bulk-billing incentive for concession-card holders in outer-metropolitan and regional areas, rather than a general incentive.	Affordability / equity
R11	Benchmark patient travel assistance against real costs and add repatriation and patient-origin fields to bed and retrieval reporting.	Regional access
R12	Protect specialist training capacity: published training-post targets by specialty and region and co-funded regional training networks.	Access (supply)

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1. Purpose and scope

This submission responds to the Department's consultation paper *Specialist Affordability: Options to address excessive fee charging* and to the broader consultation on specialist affordability and access of which it is part. It addresses the two areas the Australian Government has identified – access and affordability – from the standpoint of South Australia, and answers the provider-specific consultation questions in Appendix A.

AMA SA is the peak body for medical practitioners in South Australia across public and private practice. This submission draws on positions AMA SA has advanced in 2026 on health expenditure and productivity, emergency demand, aged care and hospital flow, and the disciplined adoption of new models of care.

The consultation paper places public hospital delivery out of scope. We respect that boundary in answering the paper's questions, but we do not accept it as a description of the problem. For most South Australians who cannot afford private specialist care, the public outpatient clinic is the only specialist option, and its capacity determines whether a private fee is ever encountered.

2. Context

2.1 The national picture

The consultation paper documents the trend: Australians spent $4.17 billion out-of-pocket on out-of-hospital specialist services in 2025, up 75.8% since 2019, and the average out-of-pocket for an initial specialist consultation rose from $94.72 to $158.75 between 2016 and 2025, against CPI growth of 32%. The Australian Institute of Health and Welfare's (AIHW) 2026 analysis adds the denominator: over the decade to 2024-25 the average specialist fee per attendance rose 0.9% a year in real terms, from $156 to $170, while the proportion of the fee covered by Medicare fell from 65% to 55%, because fees increased by 36% and benefits by 14%.[1] In non-hospital settings, 37% of specialist attendances were bulk-billed; patients who paid an out-of-pocket cost paid an average $316 a year.

The distributional data matter more than the averages. In the highest socioeconomic quintile, 43% of people had a Medicare-subsidised specialist attendance in 2024-25 against 25% in the lowest; the AIHW notes that lower-quintile patients 'may receive specialist care through public outpatient clinics', which are not captured in MBS data.[1] In the ABS Patient Experience Survey for 2024-25, 18.3% of people who needed a specialist delayed or did not attend, 8.6% cited cost, and 26.4% waited longer than they felt acceptable, this number rising to 32.3% in outer regional and remote areas.[2] Cost-related avoidance is the visible tail of a distribution whose larger part is the public queue.

2.2 Why South Australia is different

Four features of South Australia bear directly on this consultation.

- **Age:** South Australia has the second-highest proportion of people aged 65 and over of any state (19%) and the highest proportion aged 85 and over.[3] Two in three people aged over 65 see a specialist each year; demand for specialist care is structurally higher in the state.

- **Geography:** 22% of South Australians live outside Greater Adelaide in regions where the median age is about 47 against 39 in the capital.[4] There is one private hospital outside Adelaide (Mount Gambier). For most regional South Australians, 'private specialist care' means travel to the city; nationally, major cities have about 10 times more specialists per person than small rural towns.[5]

- **Public reporting:** South Australia has published specialist outpatient waiting times – median and maximum, by specialty, for each metropolitan public hospital – quarterly since 1 July 2018 for category 2 and 3 patients without appointment dates.[6] No other jurisdiction publishes on this basis. The report carries its own data-quality caveat, which we address at Recommendation 1 (R1).

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- **Fiscal restraint.** SA Health expenditure accounted for 53% of all new state government spending outlined in the four budgets to 2025-26 ($7.7 billion). SA Health's savings target rises to $563 million in 2028-29 – more than the projected net operating surplus for the whole general government sector in that year.[7] Salaried medical officers represent about 3% of the public sector workforce but 12% of employee expenses.[8] Restraint applied bluntly to that workforce is the most expensive saving a health system can make, and it will present to patients as a private fee they cannot afford.

3. Key issue one: access

3.1 The wait that is not counted

Australia publishes elective surgery waiting times from the decision to treat. It does not publish, on any consistent national basis, the interval that precedes it: from GP referral to first specialist assessment in a public clinic. That is the wait most patients who cannot afford private consultation actually experience, and it is the wait that determines whether a private fee is encountered at all. South Australia is the exception in making available relevant data. Its quarterly Specialist Outpatient Clinics Waiting Time Report shows median and maximum waits for unscheduled category 2 and 3 referrals at the Royal Adelaide, The Queen Elizabeth, Lyell McEwin, Modbury, Flinders, Noarlunga and the Women's and Children's hospitals – for example, in the March 2026 Waiting Time report, published in July 2026, the median and maximum waiting times were 22 months and 55 months respectively for dermatology at the Flinders Medical Centre, and 18 and 44 months for plastic and reconstructive surgery at the Royal Adelaide Hospital.[6]

The South Australian report also illustrates the limits of a jurisdictional dataset. SA Health itself notes that lists may include patients already seen elsewhere, that hospitals record referrals differently, and that 'the information may not be accurate, but it is the best information we have'.[6] A national minimum dataset – referral date, triage category, first-appointment date, removals without treatment, disaggregated by specialty, site and remoteness – would standardise what South Australia has started, and would cost little because the data already sit in jurisdictional systems.

3.2 The elective surgery evidence

Once a patient reaches the surgical waiting list, the gradient is visible. Nationally in 2024-25 the median elective surgery wait was 45 days but the 90th percentile was 329 days and 6.0% of patients waited more than a year; otolaryngology had a median of 99 days and a 90th percentile of 397 days, and septoplasty a median of 320 days with 31% waiting more than a year.[9] People in the most disadvantaged areas waited a median of 51 days against 38 in the least disadvantaged, and for the 25 most common procedures public patients waited 53 days against 28 for the privately insured.[10]

South Australia moved against the national trend: the *AMA Public Hospital Report Card 2026* reports the state's median wait for planned surgery rose from 47 to 52 days in 2024-25 while the national median fell to 45 days, and only 59% of category 2 (urgent) patients received surgery within the clinically recommended 90 days, down from 79% five years earlier, despite 687 additional beds coming online in the same year.

In emergency departments, 44% of patients triaged as urgent in South Australia were seen within 30 minutes against a national average of 60%, and only half of presentations were completed within four hours.[9a]

A specialty example that South Australians experience is dermatology: a Flinders Medical Centre unit reported at 1.5 FTE consultants and public waits of 12 to 18 months for a child with severe eczema.[11] A family facing that wait, and a private initial consultation of $158 plus the gap on every subsequent visit, is precisely the household the consultation paper is trying to protect – yet no fee-capping instrument reaches it.

3.3 The regional patient at both ends of the transfer

Regional South Australians face the access problem twice. Outbound, they travel to Adelaide for specialist care because it does not exist locally, at a cost the Patient Assistance Transport Scheme has not kept pace with; for a low-income patient the cost of reaching a bulk-billed appointment can

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exceed the cost of the appointment itself. Inbound, patients transferred to metropolitan hospitals frequently remain there after the reason for transfer has resolved because there are no repatriation pathways and no data fields that triggers one. Both are access failures that are invisible because nobody counts them.

3.4 Referral pathways

Much of the inefficiency in specialist access sits inside the referral. A meaningful share of referrals are requests for advice, not assessment; an MBS item that remunerates both the requesting GP and the advising specialist would resolve many without an appointment. Twelve-month referral validity generates avoidable GP attendances for stable chronic disease. Patients are rarely told their triage category or expected wait, so cannot make the informed choice – wait or pay – that the consultation paper assumes is available to them. In June 2025, AMA SA's own Access to Care Round Table, which included the Health Minister and senior SA Health representatives, identified three practical reforms (among other recommendations) that participants considered would be of greatest value to general practice: direct clinician-to-clinician contact, closed-loop referral feedback and timely discharge summaries. Each remains unresolved.

3.5 Supply: training is the binding constraint

Specialist supply is set by accredited training posts and the supervision attached to them; both sit in public hospitals under the fiscal pressure described above. The Commonwealth's June 2026 medical workforce modelling projects South Australia to have the steepest registrar shortfall in the country – 28.8% by 2033 and 47.7% by 2048 – alongside a growing surplus of junior doctors who cannot obtain training places.[12] This is the pipeline to the specialist workforce of direct relevance to this consultation.

4. Key issue two: affordability

4.1 The rebate gap is the structural driver

The AIHW decade series is unambiguous: specialist fees rose 36% and Medicare benefits 14%, and the Medicare share of the fee fell 10 percentage points.[1] Neither Medicare rebates nor private insurer benefits have been indexed to the cost of providing care; practice costs – including indemnity insurance, staff wages, premises, consumables, digital systems and accreditation – have risen faster than CPI. The out-of-pocket fee the patient is confronted with is, for most specialists, the difference created by that divergence. Reform that addresses the outlier without the rebate will leave most patients still paying what they pay now.

4.2 Excessive fees: what AMA(SA) accepts and what it does not

AMA SA accepts that a small number of specialists charge fees their colleagues regard as unreasonable, that patients need protection from them, and that the profession's existing mechanisms – including the Code of Conduct, Ahpra, health complaints entities and the Professional Services Review – have not treated fee levels as within scope. We also accept that 'reasonableness' without any definition is not operable as a regulatory trigger. Our position on the six options follows.

Option (consultation paper s.6)	AMA SA position	Reasoning
6.1 Fee transparency and patient empowerment	Support	Medical Costs Finder enhancements (insurer benefits, combined in-hospital out-of-pocket, a credible 'billing window' of observed fees) should proceed with a funded public education campaign. Provider-level publication only with the Federal AMA's prerequisites: the provider receives the underlying data and can correct or explain it before anything is published; no public naming on an automated threshold; no published range where volumes are low, data unstable or re-identification likely. In SA the last point is crucial, as in several sub-specialties a published 'typical fee' may be one

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Option (consultation paper s.6)	AMA SA position	Reasoning
		clinician's fee. Flagging providers as 'excessive' on the site should not occur until the definition at R4 is settled and tested.
6.2 Provider education/ nudge letters	Support as first step	Low cost, reversible and the appropriate way to test a definition before regulating on it. Letters should show the provider's position against specialty-specific peers, not the whole MBS.
6.3 Peer assessment	Support, with design conditions	Assessment by an existing body with clinical membership, natural-justice protections, a defined referral trigger (R4), and the power to order patient remediation. AMA SA accepts that the fee level should be within the scope of professional review; it has not been, and that gap has damaged the profession's standing.
6.4 Per-service fee caps	Oppose	Retrospective by design, punishes clinical complexity captured under a single item, invites shifting between items and outside Medicare. The paper's own analysis shows the consequences fall on the patient (withheld benefit) rather than the provider.
6.5 Annual average billing review	Support as the review trigger, not as a cap	A multiple of a properly constructed peer distribution, averaged across a billing year with an absolute-dollar materiality test, is a defensible screening flag; the paper's cross-subsidy concern is met by also flagging any single service above a high multiple. AMA SA supports its use to identify providers for 6.2 and 6.3, not as a cap, and not against the Schedule Fee.
6.6 Incentives for lower fees	Support if targeted	A general specialist bulk-billing incentive is expensive and untargeted. A concession-card incentive for outer-metropolitan and regional areas addresses the cohort most exposed, as the GP experience shows. See R10.

4.3 Defining 'excessive'

Of the three methods in section 4 of the paper, AMA SA supports the Federal AMA's position: the comparator must be a properly constructed peer distribution – built from non-bulk-billed services where an out-of-pocket was paid, with in-hospital and out-of-hospital services analysed separately, minimum provider and service volumes, and clinically comparable peer groups. It should be combined with an absolute-dollar materiality test, applied on average over a billing year and published per specialty. Including bulk-billed services depresses the median and makes common private fees look like outliers, and a fixed top percentile manufactures a set number of 'offenders' whatever the shape of the distribution. The Schedule Fee should not be the comparator: it has not been indexed to cost for two decades, which is why R3 and R4 are inseparable. A single-service high-multiple flag should sit alongside the annual average to close the cross-subsidy loophole the paper identifies. For a small jurisdiction the minimum-volume control is not a technicality – several South Australian sub-specialties are practised by one or two clinicians.

4.4 Informed financial consent, split billing and whole-of-episode billing

AMA SA endorses without qualification the AMA policy that considers informed financial consent as an ethical and professional obligation. We do not support making it directly enforceable with sanctions, because the course of treatment is not always predictable and existing regulators already address egregious conduct. Any transparency obligation should apply to all registered health practitioners; medical practitioners are not the only source of out-of-pocket exposure. 'Split billing' should be defined as a single provider fragmenting their own charge – a booking or administration fee

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invisible to Medicare – and AMA SA opposes that practice; it is not the same as the absence of a consolidated bill across multiple providers, and lead-practitioner liability for other providers' fees would raise, not lower, the patient's cost.

4.5 The largest affordability lever is public capacity

Any patient assessed within a clinically appropriate time in a public clinic has an out-of-pocket cost of zero. Under-capacity in public outpatients is therefore a regressive transfer from the budget to the patients least able to bear it, and recorded nowhere. Compassionate release of superannuation illustrates the endpoint: Australians withdrew about $1.37 billion of retirement savings for medical treatment in 2024-25, two-thirds of these Australians were aged 31 to 55 and most were on middle incomes, having certified that a treatment was necessary and 'not readily available through the public health system'.[13] This is the affordability signal the consultation paper is looking for, and it points to capacity.

5. South Australian evidence base

The table consolidates the South Australian data points on which this submission relies.

Data point	Figure	Source
Public outpatient waiting-time reporting	Quarterly since 1 July 2018; median and maximum by specialty, seven metropolitan hospitals; category 2–3 unscheduled	SA Health, Specialist Outpatient Waiting Time Report
Longest public outpatient waits, latest quarter	(Examples) Cardiology – Lyell McEwin Hospital – median wait 15 months, maximum 36 months ENT – Flinders Medical Centre – median wait 8 months, maximum 37 months Immunology – Royal Adelaide Hospital – median 19 months, maximum 49 months Ophthalmology – The Queen Elizabeth Hospital – median 15 months, maximum 69 months	SA Health, Specialist Outpatient Waiting Time Report, census date 31 March 2026, published 28 August 2026
Planned surgery, SA, 2024-25	Median wait 52 days (up from 47; national 45); 59% of category 2 seen within 90 days (79% five years earlier); 687 additional beds in the year	*AMA Public Hospital Report Card 2026*, SA; AIHW NESWTDC
Emergency departments, SA	44% of urgent (category 3) patients seen within 30 min (national 60%); 50% of presentations completed within 4 hours	*AMA Public Hospital Report Card 2026* and 2025, SA
Dermatology capacity	Flinders unit 1.5 FTE consultants; public waits 12-18 months reported	*The Advertiser*, 10 Aug 2026; AMA SA letter to Health Minister, 26 August 2026
Population age	19% aged 65+, second-highest of the states; highest share aged 85+	ABS National, state and territory population 2025

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Data point	Figure	Source
Regional population and age	22% outside Greater Adelaide; median age ≈47 vs ≈39	ABS Regional population 2023-24; ABS Census 2021 (secondary)
Private hospitals outside Adelaide	One (Mount Gambier)	SA Health; provider listings
GP bulk-billing by SA3 (context for R10)	Nationally 82% bulk-billed in 2022; by SA3, mean out-of-pocket payment ranged 46 to 99%; out-of-pocket for non-bulk-billed visits $16-$99; higher bulk-billing in most disadvantaged quintile (86%) than least (73%)	Saxby K, Zhang Y. *MJA* 2025;222(3):144-148
State health fiscal position	SA Health 53% of new expenditure over four budgets ($7.7b); savings target $563m in 2028-29	Auditor-General SA, Report 9 of 2025
Medical workforce share of cost	SMOs ≈3% of public sector workforce, ≈12% of employee expenses	OCPSE Workforce Information Report 2024–25
Projected registrar shortfall, SA	28.8% by 2033; 47.7% by 2048, the steepest in Australia	DoHDA, Whole-of-medical-workforce compendium, June 2026
Ramping-associated deaths	Coronial findings, three deaths	Coroners Court SA, 2025
Compassionate release of super (national)	$1.37b, 63,300 people, 2024-25; 75% aged 31-55	ATO statistics 2025

6. Alignment with the Federal AMA position

AMA SA's positions in this submission align with the relevant positions of the Federal AMA: the Position Statement on Setting Medical Fees and Billing Practices (2024), the Informed Financial Consent Position Statement and Guide (2024), The Gaps That Create Gaps and Prescription for Private Health (2026). This submission is also complementary to the Federal AMA's submission to this consultation (October 2026). Where this submission goes further – on public outpatient capacity, a national waiting-time dataset, regional access, training capacity and a targeted incentive – it elaborates the 'separate affordability agenda' the Federal AMA identifies, from the perspective of a state with the oldest population on the mainland, 22% of its people outside the capital, one regional private hospital, a published outpatient waiting-time series since 2018, and a projected registrar shortfall of 28.8% by 2033. These are elaborations informed by the South Australian health system, not departures from national policy.

Issue	Federal AMA position	AMA(SA) position	Status
Egregious fees	Does not support fees the majority of peers would consider unacceptable; opposes fee regulation	Same; supports targeted action against outliers	Aligned
Definition of 'excessive'	Properly constructed peer distribution (non-bulk-billed pool, comparable peer groups, minimum volumes) with an absolute-dollar materiality test; threshold triggers confidential	Same, published per specialty and averaged over a billing year, with a single-service high-multiple flag	Aligned – SA emphasises minimum-volume controls because of

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Issue	Federal AMA position	AMA(SA) position	Status
	validation, not a finding; Schedule Fee rejected as benchmark		small specialty numbers
Peer assessment	Stage 3 escalation of serious, repeated, unexplained cases to appropriately constituted peer review with specialty expertise, procedural fairness and appeal rights; remediation to the patient prioritised	Supports fee level being brought within the scope of an existing professional body, with natural justice and patient remediation	Aligned
Fee caps	Opposed	Opposed	Aligned
Rebate indexation	Central Federal AMA ask (*Gaps That Create Gaps*)	Same; inseparable from any excessive-fee definition	Aligned
Informed financial consent	Ethical and professional obligation; guidance and templates; not legally enforceable with sanctions	Same	Aligned
Split billing / whole-of-episode billing	Opposes single-provider fee splitting; opposes lead-practitioner liability for others' fees	Same, with a request for precise statutory definition	Aligned
Medical Costs Finder	Supports a billing window, not a government 'right price'; provider data, correction and appeal before publication; no automated naming; protect low-volume services	Same; education campaign and evaluation before further legislation	Aligned – SA emphasis on re-identification risk in small specialties
Transparency scope	Applies to all practitioners	Same	Aligned
Public outpatient waits / NHRA	Calls for NHRA to address excessive public outpatient waits	Same; proposes the SA quarterly report as the national template	Elaboration of the Federal agenda – SA supplies the national template (quarterly report since 2018)
Specialist bulk-billing incentive	Part of the 'separate affordability agenda' (targeted patient support); notes the paper rejected incentives on cost grounds	Supports a **targeted** concession-card incentive in outer-metropolitan and regional areas	Elaboration of the Federal agenda, informed by SA's regional population, one regional private hospital and specialist maldistribution
Scope of practice as an access remedy	Evaluation before expansion	Same	Aligned

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In summary, AMA SA and the Federal AMA hold the same position on the definition of excessive fees, the trigger for review, the process that follows it, fee caps, rebate indexation, insurer benefits and transparency. The South Australian submission adds the public-capacity, regional and workforce evidence that a national submission cannot carry at jurisdictional depth, and it has been provided to the Federal AMA as input to its own draft.

7. Recommendations and justification

R1 — National specialist outpatient waiting-time dataset

South Australia has shown since 2018 that public reporting by specialty and hospital is feasible; its own caveats show why a national standard is needed. Referral date, triage category, first-appointment date and removals without treatment, by specialty, site and remoteness, would make the wait that precedes every private fee visible and enable the Commonwealth to direct capacity to where it is most needed.

R2 — Public capacity as the primary affordability lever

Public assessment within a clinically appropriate time has an out-of-pocket cost of zero. NHRA funding should be tied to outpatient access measures as it is to emergency and elective ones, and state efficiency savings from non-clinical reform should be quarantined for clinical capacity rather than returned to consolidated revenue.

R3 — Restore the value of the rebate

A 36% rise in fees against 14% in benefits over a decade is at the basis of most out-of-pocket growth. Independent indexation against a health-specific input-cost index, and mandatory insurer reporting of benefit levels relative to fees, would address the factor that other options in the paper ignore.

R4 — Define the trigger for review as a published multiple of a properly constructed peer distribution, with an absolute-dollar materiality test

Consistent with the Federal AMA's staged approach: the comparison pool excludes bulk-billed services; in-hospital and out-of-hospital are separated; peer groups are clinically comparable with minimum volumes; distance from the median is tested together with the actual dollar difference and the long-tail shape; and a threshold triggers confidential validation, not a finding. Published per specialty so that practitioners know the standard in advance. The Schedule Fee is not used as the comparator until re-indexed to cost (R3). A single-service high-multiple flag closes the cross-subsidy loophole the paper identifies.

R5 — Peer assessment through an existing professional body

The consultation paper notes that regulators have treated fee level as out of scope. AMA SA supports bringing it within scope of a body with clinical membership, natural-justice protections and the power to order remediation to the patient – the element that fee caps cannot deliver.

R6 — No per-service caps; publish monitoring

The consultation paper's own risk table lists price signalling, cross-subsidy, item shifting, exit from Medicare and patient detriment from withheld benefits. Per-service caps trigger all five. Any intervention adopted should be accompanied by published monitoring of fee distributions so that signalling and shifting are detected early.

R7 — Medical Costs Finder, education, evaluate before legislating

Transparency reduces out-of-pocket costs only when patients use it. Fund the campaign, publish the evaluation, and legislate further only if the evaluation shows it is needed.

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R8 — Informed financial consent as a professional obligation; all practitioners; define 'split billing'

Sanction-backed consent punishes the unpredictability of medicine rather than any failure of disclosure; obligations confined to medical practitioners are inequitable and ineffective; imprecise definition of split billing will regulate the wrong conduct.

R9 — GP–specialist advice items, longer referral validity, closed-loop feedback

Each converts an appointment that need not happen into advice that resolves the question or gives the patient the information – triage category and expected wait – on which the consultation paper assumes they can choose.

R10 — Targeted specialist bulk-billing incentive

The GP incentive worked where it was targeted. A concession-card incentive in outer-metropolitan and regional areas reaches the households in the lowest quintile who use specialist care least and wait longest, at a fraction of the cost of a general incentive.

R11 — Regional access at both ends of the transfer

Patient travel assistance should be benchmarked to real costs; repatriation-ready, patient-origin, reason-for-non-transfer and destination fields on existing bed and retrieval censuses so that avoidable transfers are prevented and prompt repatriation is triggered.

R12 — Protect training capacity

Publish training-post targets by specialty and region, and co-funded regional training networks with supervision explicitly funded, so that the contraction the Commonwealth's own modelling projects for South Australia is visible when it happens rather than a decade later.

8. Conclusion

The questions this consultation asks – why patients pay, and what protects them when the price is unreasonable – have a South Australian answer that is sharper than the national one. Here the population is older, the distances are longer, the public system is under explicit fiscal restraint, and the wait that precedes every private fee is already counted and published. AMA SA supports action against genuinely excessive fees, and accepts a defined trigger and profession-led review as the way to take it. It asks the Australian Government to pair that action with the two measures that determine what most patients actually pay: a rebate that keeps pace with cost, and public specialist capacity that keeps pace with need.

AMA SA would welcome the opportunity to discuss this submission with the Department and to provide South Australian clinical and data input to the design of any option taken forward. Please contact me at president@amasa.org.au to discuss this at any time.

Yours sincerely



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Attachment: Appendix A, references

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Appendix A — Responses to provider-specific consultation questions

Question	AMA SA response
Which framework best captures when a fee is excessive?	Peer comparison against a properly constructed specialty distribution (non-bulk-billed services, comparable peer groups, minimum volumes) combined with an absolute-dollar materiality test (R4), used as a trigger for confidential validation and review rather than as a cap or a finding; reasonableness retained as the standard applied at review. Not a Schedule-Fee benchmark.
Have you witnessed peers charging excessive fees?	Yes, in a small minority of cases. The profession's inability to act on them is a reputational cost to the majority.
Will fee transparency address excessive fees?	Partly (3/5). A billing window informs choice where choice exists; it does not create capacity, and a published upper figure risks signalling upward. Must include insurer benefits, give providers the data and a right of correction before publication, and protect low-volume services.
Will peer review address excessive fees?	Yes, if designed as at R5 (4/5).
Will price caps address excessive fees?	No (1/5). Retrospective, punishes complexity, shifts cost between items and outside Medicare, and withholds benefit from the patient.
Will incentive payments address excessive fees?	Not excessive fees specifically (2/5); a targeted incentive addresses affordability for the most exposed cohort (R10).
Specialist fees are too high	Disagree as a generalisation (2/5); the AIHW series shows average real fee growth of 0.9% a year, and the gap is driven by benefit indexation.
Specialists should charge any fee they deem acceptable	Disagree (2/5); fees should be reasonable and disclosed, and outliers should be reviewable.
Government has a role in preventing excessive fees	Agree (4/5), by transparency, a defined trigger and profession-led review — not by caps.
There should be consequences for excessive fees	Agree (4/5), including remediation to the patient.
Higher fees deliver higher quality	Disagree (1/5).
Factors considered in setting fees	Practice costs (staff, indemnity, premises, equipment, digital, accreditation), time and complexity, unfunded obligations (supervision, public work), and the patient's circumstances; the AMA fee guide as a reference.
Other policy options not discussed	Public outpatient capacity and a national waiting-time dataset (R1–R2); rebate indexation (R3); GP–specialist advice items and referral reform (R9); regional travel and repatriation (R11); training capacity (R12).
Implications for private health insurance	Any definition of excessive must account for insurer benefit levels, which vary and are opaque; insurer reporting of benefits relative to fees (R3) is a precondition. Fee regulation that ignores the insurer's share will be borne by patients.
Other risks	Retention: characterisation of the specialist workforce as the cause of unaffordability is not supported by the fee distribution and is prompting some to reduce public and private participation; South Australia's projected registrar shortfall makes this a supply risk.

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Question	AMA SA response
Billing processes that misattribute out-of-pocket costs	Yes. Practice software frequently attributes the whole out-of-pocket to the first item of a multi-item service; item-level analysis of such data will misidentify "excessive" fees. Analysis should be at episode level, and providers should be able to respond before any action.

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