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Royal Australasian College of Surgeons (RACS) Submission to the House of Representatives Standing Committee on Health, Aged Care and Disability ‘Inquiry into Access to and Affordability of Medical Specialists in Australia’

19 August 2026

Executive Summary

The Royal Australasian College of Surgeons (RACS) is the peak body for surgical education, training, standards and professionalism in Australia and Aotearoa New Zealand, representing around 9,000 surgeons, together with 1,300 surgical trainees and specialist international medical graduates across nine surgical specialties.

RACS welcomes the Committee’s Inquiry and strongly supports its objective of improving equitable access to specialist care and reducing the cost burden on patients.

This submission is informed by the RACS *Access to Surgery, Sustainability and Patient Affordability Survey*, which captured the views of more than 700 surgical Fellows practising across Australia – one of the most comprehensive surveys of its kind undertaken by a specialist medical college – together with existing College policies, member consultation and system-wide evidence.

Access and affordability challenges across Australia’s health system are complex and systemic. In this context, RACS welcomes the emphasis the Committee places on these challenges and the length of time being dedicated to examining these issues in detail. RACS is committed to making its surgical leaders available to support the Inquiry throughout its deliberations, including sharing in detail the insights from the survey of our Fellows.

There are many contributing factors to affordability and access challenges: rising practice costs – most notably medical defence organisation (MDO)/medical indemnity costs; increasing complexity and comorbidity of patients, as well as complexity of diagnosis and treatment; Medicare rebates for consultations and procedures that do not reflect contemporary practice, exacerbated by freezes to Medicare indexation; insufficient scrutiny of private health insurers, the inconsistency of fee schedules across insurers, and their opaque known/no fee gap arrangements; constrained public hospital capacity and funding; and appropriate policy settings to ensure the surgical workforce is evenly distributed.



Committed to
Indigenous health

RACS can use its data, workforce analysis and relationships with surgeons and specialty societies to assist governments and health services to interpret workforce modelling, identify emerging access and affordability pressures, as well as develop appropriate training and service responses.

In this context, the College has worked with its Fellows and specialty societies to develop a number of case studies to contribute to the Committee's Inquiry.

RACS supports meaningful fee transparency, informed financial consent and proportionate action against genuinely unreasonable charging. However, specialist affordability cannot be addressed through simply focussing on fee disclosure or mandated fee directives – it requires addressing all of the complex factors contributing to access and affordability challenges across the system.

Recommendations

RACS recommends that the Committee consider:

1. An independent, profession-led review of MBS rebates for specialist consultation and procedural items, with a clear mandate to realign rebates with the time, complexity, expertise and resources required to deliver contemporary surgical care – including recognition of complex consultations, multidisciplinary team participation, and the substantial pre- and post-procedural work that currently attracts little or no remuneration.
2. Reviewing MBS items to improve and increase access to surgeons via virtual care where clinically appropriate, particularly for those in regional and rural areas.
3. The restoration of appropriate, ongoing indexation of Medicare rebates against the real cost of delivering care, benchmarked where relevant against the cost of delivering equivalent services in the public system, together with a redesign of the Medicare safety net and incentives for no-gap and known-gap billing.
4. Support for the routine collection and publication of public specialist outpatient waiting times – including time from referral to first specialist assessment and the geographic distribution of services – alongside existing elective surgery reporting, so that patients, referrers and governments can see the true level of unmet demand.
5. Minimum standards for private health insurance coverage, encompassing: standardised disclosure of coverage and exclusions; minimum benefit floors for clinically necessary care; item-level transparency of benefits; real-time confirmation of coverage for patients and practices; clear rules for complications and emergency treatment arising during an insured admission; and standard response periods for insurer approvals and ex-gratia requests. This should be accompanied by redesign of gap-cover schemes to minimise cliff-edge effects and accommodate the complexity and unpredictability of surgical care, greater uniformity between insurers, and transparency of the arrangements between hospitals and insurers. This should include review of the \$500 known-gap threshold, which has remained unchanged for many years. Properly reviewing this could have the benefit of simplifying billing, leading to a single bill for surgical procedures and in turn improving access to medical specialists.
6. Modernised funding arrangements for medical devices and technologies, including custom-made and essential non-implantable devices that fall outside existing funding mechanisms.
7. National, specialty- and region-specific workforce planning, undertaken in consultation with specialist medical colleges and specialty societies and informed by a freely available workforce survey of each specialty by region and facility. This planning should guide expanded training places, regional incentives and streamlined processes for specialist international medical graduates, and building and sustaining training capacity in the areas of greatest need over the long term.

8. Increased investment in public hospital surgical capacity – an increase in the number of operating theatres, increased theatre utilisation, beds and workforce – with improved national reporting of theatre usage, outpatient and elective surgery waiting lists and workforce distribution to support evidence-based planning and the surgical training pipeline.
9. MBS items that enable surgeons to provide care to patients under a broad scope of practice, particularly to meet the needs of rural and regional communities.
10. Support for a consistent national Informed Financial Consent Framework accompanied by episode-of-care transparency, so that patients receive clear, timely information about the expected costs of all contributors to their care – surgeon, anaesthetist, assistant, diagnostics, hospital and insurer – rather than attributing the whole cost to a single practitioner.
11. Proportionate, evidence-based measures to address unreasonable fees, distinguishing genuine outlier billing from structurally elevated gaps caused by inadequate MBS rebates, complexity, multiple providers and limited public alternatives. These measures should take the form of a mediation-focused, commission-style framework drawing on peer review, education and ethical guidance, rather than ‘blunt’ fee caps or regulation calibrated to a small minority. This role should be independent with oversight from clinicians who have expertise in the relevant sectors. RACS supports its surgical leaders’ engagement in this independent process.
12. Tort reform to moderate medical indemnity premiums, drawing on the New Zealand experience, and examination of hospital-avoidance models such as hospital-in-the-home to reduce the cost of private episodes of care.

Feedback from Fellows to inform the Inquiry

The cost of operating a private practice

Most surgeons working in the private sector are individual small business owners who have faced rising practice costs and declining real reimbursement from Medicare and private health insurers for many years. Fellows identified medical indemnity insurance (65.9%), administrative staffing (63.9%) and practice infrastructure and consulting rooms (60.0%) as the principal contributors to practice expenses, together with the costs of insurance and of complying with accreditation and regulatory requirements. These are fixed, unavoidable costs that must be met before a surgeon receives any personal income.

Many of the aspects involved in operating a private surgical practice are not remunerated, and this contributes to access and affordability challenges.

Post-operative follow-up by practice nurses is unfunded, requiring surgeons to meet this cost within the operation of their practices. Similarly, consultations following surgical procedures are not remunerated in a way that reflects the time involved or the professional expertise developed through years of training required to provide this advice and support.

Practice software and IT systems are subscription-based and contribute to practice costs, as do compliance requirements with medical record-keeping obligations, including for the ongoing support required for NDIS participants.

A large number of RACS Fellows also dedicate their time to teaching surgical trainees on a pro bono basis.

On-call work for surgeons is also often unremunerated, particularly in private hospitals; and while virtual access to medical imaging now enables surgeons to review cases remotely, this work remains largely unpaid, or is remunerated in a way that bears no relationship to the cost of the service and the expertise being provided.

The barriers to access

Fellows identified the biggest challenges facing patients in accessing surgical services as inadequate public hospital funding (70.3%), theatre closures and limited operating lists (50.9%), private health insurance settings (50.9%), lack of hospital beds (46.5%) and an increasing number of patients without insurance (32.7%). These barriers are exacerbated in regional Australia, where shortages of specialists, operating theatre access and anaesthetic services compound the problem.

How surgeons are responding to these challenges to support access

Around 90% of surveyed Fellows report using no-gap, known-gap and bulk-billing arrangements where possible to reduce patient costs, and offering reduced fees to particular groups of patients. At the same time, Fellows report growing numbers of patients delaying care or electing to wait for care in the public system because they cannot afford any gap or the insurance product they would need, seeking lower-cost options or payment plans, or deciding not to proceed at all.

Insurance settings and inadequate Medicare funding are key drivers of this.

What reform Fellows prioritise

Asked which reform would most improve access, 67% of Fellows nominated modernisation of MBS rebates so that they reflect the time, complexity, expertise and resources required to provide surgical services. This was followed by increased public hospital investment (55.4%) and reform of private health funding mechanisms (36.2%).

Workforce distribution and service capability

The National Medical Workforce Strategy 2021–2031 recognises that Australia's principal medical workforce challenges include geographic maldistribution, imbalances between specialties and insufficient coordination between the organisations that fund, train, employ and regulate doctors.

These issues are particularly important in surgery. National workforce numbers can appear broadly adequate while particular communities continue to experience limited or fragile access to services. Surgeon location data also does not fully describe outreach, visiting services, multi-site practice or the wider geographic catchments served by individual hospitals.

The presence of a surgeon in a region does not, by itself, establish that a sustainable surgical service exists. Smaller services may depend on a very limited number of clinicians and have little capacity to absorb leave, illness or workforce turnover. Visiting services may provide highly productive individual operating lists but remain constrained by their frequency and continuity. Services must also maintain sufficient teams, rosters and on-call arrangements to operate safely, regardless of whether annual activity appears to justify a particular number of full-time-equivalent positions.

RACS' workforce planning work has therefore emphasised the need to connect workforce distribution with service capability. Relevant capability includes operative teams, theatre capacity, anaesthetic and diagnostic support, inpatient and critical care capacity, referral and escalation arrangements, and sustainable links between regional services and larger specialist centres.

This approach can help distinguish between:

- A shortage or maldistribution of surgeons
- Limitations in infrastructure or supporting workforces
- Service configuration and funding constraints
- The appropriate concentration of complex care in specialised centres

Not every surgical procedure can or should be delivered in every community. Highly specialised and low-volume care may appropriately be concentrated in centres able to maintain the required expertise, infrastructure and multidisciplinary support. At the same time, patients should not be required to travel to metropolitan tertiary hospitals for care that could be delivered safely and sustainably closer to home.

Service planning should therefore identify which types of care should ordinarily be available locally, which may be provided through networked or visiting models, and which should be concentrated in specialist centres.

Measuring need, access and productivity

Surgical workforce and service planning frequently relies on historical service activity. This is an important evidence base, but activity records what the existing system has been able to deliver. It does not necessarily describe the full level or distribution of community need.

Patients may experience delays before specialist assessment, travel to another region, enter the private system because public care is unavailable, postpone care because of cost or distance, or not receive care at all. These experiences may not be visible in datasets based primarily on completed services.

RACS' workforce review found that observed activity can reflect existing capacity, access pathways and service models rather than the level of care that would be delivered if those constraints were removed. This limits the use of historical utilisation alone as a measure of future need, particularly in communities where services are intermittent or unavailable.

Waiting times remain an important measure of patient access, but they should be considered alongside broader indicators of service performance. Governments could also examine:

- The number of patients entering and leaving waiting lists
- Changes in the overall backlog
- Surgical throughput
- Cancelled or postponed procedures and their causes
- Funded, staffed and completed theatre sessions
- Constraints associated with beds, patient flow and discharge
- The availability and frequency of local services
- Patient outcomes and experience

In this context, productivity should not be understood simply as requiring clinicians to work faster. Surgical system productivity is the capacity to convert available workforce, infrastructure and funding into clinically appropriate, timely and safe care.

RACS Fellows have identified improved theatre utilisation, patient flow and discharge processes, increased theatre and bed capacity, and reduced administrative burden as opportunities to improve access. These issues warrant greater attention alongside conventional waiting-time measures.

The Structural Drivers of Cost and Access

Medicare rebate inadequacy

Healthcare delivery costs have risen faster than CPI for decades, while Medicare rebates have lagged behind even general inflation.

The result is a steadily narrowing margin for surgical practices, rising out-of-pocket costs for patients, and growing risk to the financial viability of private specialist practice. Once realigned with the actual cost of delivering care, the MBS should remain indexed to the growth in healthcare costs, with the Medicare safety net and no-gap and known-gap billing incentives redesigned in parallel. Targeted tax settings for surgical practices – small businesses contending with complex and regional caseloads – would further ease the pressure created by years of inadequate indexation.

RACS also supports the Committee considering how the MBS can better support virtual care in surgical practice. The way Australians access healthcare has changed, especially in the last decade. MBS policy settings and remuneration have not kept pace with this.

RACS supports surgeons having better access to MBS items for virtual care which would be a simple way of improving access to and affordability of the care surgeons provide, especially for people in regional and remote communities.

Private health insurance

The private health insurance sector requires reform directed at transparency of benefits, adequacy of funding for all clinically necessary procedures, reduction of patients' out-of-pocket costs and the long-term viability of private hospitals. Greater uniformity in insurers' gap arrangements and clearer consumer information from insurers are central. The burden of opaque and inconsistent products often falls on specialists and their staff to explain to patients and substantially contributes to patients' frustration as well as access and affordability challenges.

Reform must also extend beyond insurance products to the design of gap-cover schemes themselves. Products are what consumers buy; gap schemes are the arrangements between insurers and practitioners that largely determine patients' out-of-pocket costs. Under current scheme design, a small difference in the total fee can trigger the loss of the entire enhanced benefit, producing a disproportionate out-of-pocket cost for the patient. This cliff-edge discourages specialists from taking

on complex or unpredictable cases within gap cover – precisely the cases for which patients most need financial protection. A modernised gap protection framework should reflect contemporary practice costs, minimise cliff-edge effects and accommodate the inherent complexity of surgical care.

The Committee should also examine the \$500 known-gap threshold that applies under most insurers' gap-cover arrangements. This figure has remained unchanged for many years, despite substantial growth in practice costs over the same period.

Reviewing the known-gap threshold could keep more procedures within gap cover – simplifying billing, and in turn reducing patients' overall out-of-pocket costs.

Funding follows profitability, not clinical value

Discrepancies in procedure funding mean that some clinically important work is not cost-effective for private hospitals, which understandably decline to support unprofitable activity – reducing access for patients in need. All parties should commit to eliminating genuinely low-value care; equally, care that is of demonstrated value must be adequately supported wherever it is delivered.

A sustainable private sector contributes to patient access and affordability. Every procedure the private system cannot viably deliver shifts onto public waiting lists which are underinvested in and already at or over capacity. Accordingly, supporting the viability of private hospitals and specialist practice directly contributes to access for all patients.

Public hospital capacity, workforce and the training pipeline

Government investment is needed to expand public surgical capacity: more available operating theatres, better theatre utilisation, improved elective surgery waiting times and sustained workforce investment. Workforce planning must be conducted in consultation with the colleges and jurisdictions and be specialty- and region-specific. Improved national reporting of theatre utilisation, outpatient waiting lists, surgical activity and workforce distribution would give governments and stakeholders the evidence needed to resolve capacity constraints, plan equitably for rural and regional access, and forecast the surgical training pipeline. A detailed, freely available workforce survey of each specialty – by region, facility and catchment population – is overdue, alongside a streamlined specialist international medical graduate pathway, expanded training places and regional incentives.

Addressing Unreasonable Fees Proportionately

RACS accepts that a minority of opaque or excessive billing practices exist and that they erode public trust. Although few in number, these cases feature disproportionately in public commentary. The College supports a balanced response that differentiates legitimate cost recovery from egregious billing, and that strengthens transparency and accountability while safeguarding clinical independence, patient choice and the sustainability of quality surgical care.

Transparency initiatives will only serve patients if fee information is presented with clinical context, case-mix adjustment, procedural fairness and strong governance. Patients with chronic disease and multiple comorbidities – an increasing share of surgical caseloads – require longer procedures, carry greater clinical risk and need more postoperative care. Where published information fails to account for case mix, patients may misread the reasons for fee variation, damaging a surgeon's reputation and referral base and, ultimately, discouraging surgeons from taking on complex cases – reducing access for the patients who most need it.

The appropriate mechanism for addressing genuinely unreasonable charging is a practitioner-informed, mediation-focused framework – drawing on peer review, education and ethical guidance – rather than punitive government price regulation. A commission-style body could resolve grievances in a conciliatory way and reduce recourse to lengthy and expensive litigation. Specialist medical colleges

are not regulators: they lack the statutory powers, funding and insurance capacity for investigative or enforcement functions, and should not be asked to perform them.

Complementary tort reform, informed by the New Zealand approach, would moderate the medical indemnity premiums that Fellows identify as their single largest cost pressure. More broadly, future reform should scrutinise regulations that add to practice costs – and can therefore create barriers to access and affordability – without improving patient safety or surgical outcomes, while supporting sustainable specialist practice and protecting clinical discretion.

Conclusion

Meaningfully addressing access and affordability requires examining all of the contributing factors comprehensively. RACS' position is that this can best be achieved through collaboration between the specialist sector, private hospitals, insurers and all levels of government, as well as confronting the maldistribution of the surgical workforce. Affordability pressures arise principally from inadequate Medicare rebates; rising practice costs (especially medical indemnity insurance); the increasing cost and eroding value of private health insurance; constrained public hospital capacity; workforce maldistribution and shortages in certain sectors; and limited theatre availability.

Improving access will therefore require coordinated planning between governments, health services, RACS and other professional bodies. Workforce, training, infrastructure and service capability must be planned together and aligned with the needs of the communities they are intended to serve.

RACS supports stronger transparency and informed financial consent, provided reforms are grounded in clinical context, fairness and sound governance – informing patients without misleading them, and without deterring surgeons from complex work.

The College looks forward to working with the Committee throughout the course of its Inquiry.



Dr Philip Morreau

President, Royal Australasian College of Surgeons

Appendix: Surgical Case Study Examples

The following examples, drawn from surgical practice across the College's specialties, illustrate how current funding settings fail to reflect the real cost and content of specialist surgical care.

Case example 1: A common day procedure – skin cancer excision and grafting (plastic and reconstructive surgery)

A patient undergoes excision of a lower-leg skin cancer with a split-skin graft – a common procedure, particularly in older patients whose comorbidities, such as diabetes or peripheral vascular disease, increase the risk of wound complications. Operating time is approximately 45 minutes, usually as day surgery. The relevant MBS items are 31363 (rebate \$284.95) and 45440 (rebate \$331.70); under the multiple-procedure rule the total rebate is \$474.18 (75% Medicare, 25% private health insurance).

Against that rebate: indemnity attributable to the case is approximately \$100. Aftercare typically involves at least two nurse visits (nursing at about \$50 per visit plus roughly \$40 of consumables each visit), and most patients also require a post-operative consultation with the surgeon to discuss pathology results – all included within the MBS aftercare period. If minor wound-healing problems occur, as is common in this cohort, further nurse visits and consumables are needed. Combined with indemnity, these direct costs alone can exceed a quarter of the total MBS fee – before any allowance for rent, staffing, administration or equipment, and before the surgeon receives any income.

Case example 2: The hidden work of complex specialist care – a fenestrated endovascular aneurysm repair (FEVAR) (vascular surgery)

Illustrating the unfunded cognitive, multidisciplinary and coordination work underpinning modern specialist care

Clinical background

Mr KC, a 78-year-old man with significant cardiovascular and medical comorbidity, was referred with an enlarging juxtarenal false abdominal aortic aneurysm, increasing from 43 mm to 47 mm. His history included previous thoracic endovascular aortic repair (TEVAR), coronary artery disease requiring coronary intervention, atrial fibrillation, COPD and previous treatment for both colorectal and hypopharyngeal cancer.

Given the aneurysm's location, previous aortic intervention and significant comorbidity, this was not a routine abdominal aneurysm. Conventional open surgery carried an estimated perioperative mortality exceeding 25%, making it an inappropriate option. The preferred treatment was a custom-designed fenestrated endovascular aneurysm repair (FEVAR) using a patient-specific graft. This required extensive anatomical analysis, personalised device design and multidisciplinary planning before any decision to proceed could be finalised.

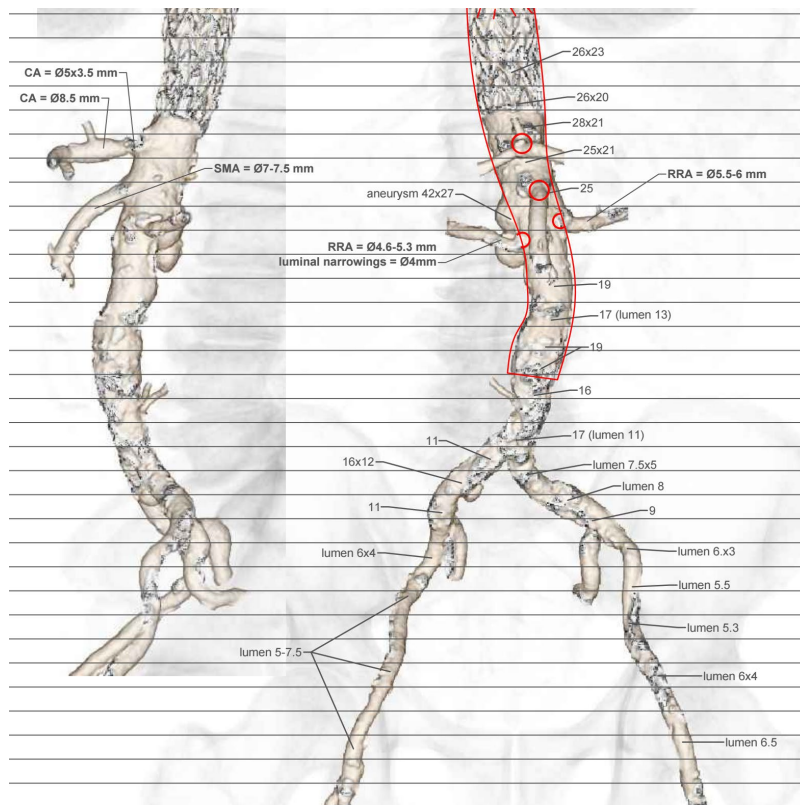


Figure 1. Patient-specific anatomical planning sketch – customised aortic graft

The treating vascular surgeon undertook a comprehensive review of the CT angiography, independently measuring the aneurysm, proximal sealing zone, visceral branch anatomy, luminal diameters and iliac access vessels. These measurements were transferred to a customised planning worksheet to design a patient-specific fenestrated endograft. This highly specialised cognitive task is essential to procedural safety but attracts no separate Medicare remuneration.

The hidden work behind a single operation

Although the patient ultimately underwent successful FEVAR, the procedure represented only a small proportion of the total professional work involved.

1. Advanced imaging assessment. The treating surgeon must personally review the CT angiography, performing detailed three-dimensional anatomical measurements including proximal sealing zone assessment, renal artery orientation, superior mesenteric artery position, coeliac artery measurements, luminal diameters, iliac access vessel suitability and the relationship to the previous thoracic stent graft. This work required approximately 30–45 minutes of specialist interpretation.

2. Customised endograft design. The patient's anatomy required a bespoke customised fenestrated graft. The treating surgeon reviewed and approved anatomical measurement worksheets, graft planning documentation, fenestration positioning and size, and branch vessel alignment and lengths, with iterative review with the manufacturer and potential design revisions before approval. Custom device planning commonly requires 1–2 hours of consultant time and is entirely unfunded.

3. Multidisciplinary team review. The case was presented at the vascular and radiology multidisciplinary meeting, which reviewed imaging, anatomical suitability, operative risk, treatment alternatives, funding pathway and procedural feasibility. The documented consensus was to proceed with fenestrated EVAR at a private hospital, with the local public hospital as the fallback (where the device costs would be borne by the hospital) if ex-gratia approval was unsuccessful. The MDT

process is an essential clinical governance activity that improves patient safety but attracts no Medicare reimbursement.

4. Communication with industry. Development of the customised graft required direct liaison between the treating surgeon and the device manufacturer regarding manufacturing specifications, technical feasibility and timelines, graft size (access introducer diameter) and access for branch vessels. These highly specialised discussions are necessary before surgery can proceed yet receive no remuneration.

5. Funding negotiations. Because of the complexity and cost of the customised graft, the treating surgeon prepared detailed correspondence requesting ex-gratia approval from the patient's insurer. This involved preparation of clinical justification and explanation of why open surgery represented unacceptable risk; explanation of imaging findings and justification that FEVAR offered lower morbidity, shorter hospitalisation and reduced ICU utilisation; and liaison with the private hospital, insurer and graft manufacturer for quotation. This advocacy ensured the patient could receive the safest available treatment but required substantial additional consultant time.

6. Operative planning. Additional work included theatre coordination, hybrid operating room scheduling, inventory planning across multiple providers, customised device logistics, imaging equipment preparation, image analysis and programming, and multidisciplinary team role delegations and planning.

7. Comprehensive patient counselling. Multiple consultations were required to discuss operative risks, alternative treatments, expected outcomes, lifelong imaging surveillance, informed financial consent and perioperative medication management. These extended consultations substantially exceed the assumptions underpinning standard Medicare consultation items.

Estimated additional professional time

Activity	Approximate time	Medicare remuneration
Independent CTA review	30–45 min	None
Three-dimensional anatomical measurements	30 min	None
Custom graft planning	1–2 hours	None
Industry consultation	30–60 min	None
MDT participation	30–60 min	None
Funding submissions and insurer discussions	30–60 min	None
Hospital planning and logistics	30–60 min	None
Extended informed consent	45–60 min	Standard consultation only
Post-operative documentation, correspondence and surveillance planning	30 min	Procedure item(s)

Estimated unfunded professional time: 5–8 hours

The financial consequences of appropriate clinical decision-making

An often-overlooked aspect of specialist practice is that most of this work must be completed before a final decision regarding intervention can be made. In many complex cases, detailed imaging review, multidisciplinary discussion, anaesthetic assessment or further investigations ultimately determine that

the patient should not undergo surgery. This is good clinical practice and protects patients from procedures where the risks outweigh the benefits.

However, under the current Medicare funding model, if surgery does not proceed, the specialist receives only a single consultation rebate. The many hours spent reviewing imaging, undertaking anatomical measurements, participating in MDT meetings, designing customised procedures, communicating with industry, negotiating with insurers and coordinating care receive no remuneration whatsoever. The current funding model therefore places the financial risk of appropriate clinical decision-making entirely on the specialist. It recognises procedural activity but largely ignores the expert cognitive work required to determine whether a procedure should be performed. The decision not to operate is often as clinically demanding – and as valuable to patient safety – as the decision to proceed.

Outcome

Following approval and comprehensive planning, the patient underwent successful fenestrated endovascular repair of the juxtarenal abdominal aortic aneurysm using a customised fenestrated stent graft. The procedure achieved exclusion of the aneurysm while preserving perfusion to the visceral vessels, with the predicted short admission and minimal morbidity – demonstrating the value of the investment in meticulous pre-operative planning and multidisciplinary care.

Summary

Current Medicare funding rewards procedures but largely ignores the complex cognitive work required to determine whether a procedure should be performed. The expertise involved in safely deciding not to operate is just as important to patient outcomes as the operation itself, yet under the current system this work is almost entirely unfunded. This case demonstrates that contemporary specialist practice involves many hours of highly skilled clinical work before and after the patient enters the operating theatre. Advanced imaging review, multidisciplinary case conferences, personalised procedural planning, discussions with industry, negotiations with insurers and coordination of care are fundamental to safe, high-quality outcomes but receive little or no recognition within the current Medicare Benefits Schedule. Without acknowledging and appropriately funding these activities, the MBS risks undermining the sustainability of complex specialist services essential to world-class patient care.