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Jacqualine Myint
Department of Health, Director

Private Health Strategy Branch
Consumers Section

Via email: Jacqualine.Myint@Health.gov.au; OOPTransparency@health.gov.au

Dear Ms Myint,

The Royal Australasian College of Surgeons (RACS) appreciates the opportunity to provide input into the Department of Health's *Out-of-Pocket Costs Transparency by Default Consultation Forum*, which took place on 18 May 2026, and we would also like to thank you for sharing your presentation materials with RACS. RACS would like to acknowledge your ongoing engagement and progress made to date by the Department working collaboratively with specialist medical colleges to ensure that patients who use or plan to use the private health care system understand how much they can expect to pay for their medical services, and the costs involved in providing them with informed financial consent.

RACS is in support of patients being provided with clear, useful insights regarding possible out-of-pocket expenses. RACS also appreciate that various stakeholder feedback has been considered in the ongoing development of the Medical Costs Finder (MCF) reforms. These include moving from single figures to a range of fees, incorporating a broader procedural package consisting of additional costs outside of just the surgeon's fee, and the continued use of disclaimers and contextualised information throughout the MCF website. The new amendments demonstrate improvement over the previous iteration in tackling some of the complexities when providing surgical services. However, there is still much more work to be done.

Executive Summary

RACS is concerned that the fee transparency reform may oversimplify the complexities of the health care system by moving their focus away from general affordability and access issues to the much narrower view of specialist fees. RACS wants to make sure that the multiple factors behind the costs of providing care are adequately accounted for in publicly reported data. Sucha as:

- the complexity of patients
- provision of multi-disciplinary care
- arrangements between hospitals and insurers
- workforce shortages
- distance to travel
- the provision of long-term, post-operative care

If publicly reported data do not take these factors into account, then the reporting risks could create misleading comparisons, discouraging the provision of complex and resource intensive care (further impacting workforce sustainability given the current rise in medico-legal pressures and increasing operating costs). Overall, this may perpetuate a lack of confidence in health and healthcare professionals and institutions, particularly as it relates to growing misinformation and reliance on unregulated sources of health information for patients.

For this reason, RACS recommends that the finalised fee transparency framework includes the following priority areas:

- methodological rigour in the collection and analysis of health care fee transparency data
- clinical contextualisation of collected fee transparency data
- procedural fairness in the public reporting of fee transparency data
- clear accountability by governments for the interpretation and outcomes of the public reporting of fee transparency data.

Background

RACS is the leading advocate for surgical standards, professionalism and education in Australia and Aotearoa New Zealand. The College represents close to 8,000 surgeons, and 1,300 surgical trainees and specialist international medical graduates (SIMGs). As a not-for-profit organisation, RACS funds surgical research, advocates for members and patients, and supports healthcare, as well as providing surgical education in the Indo-Pacific. RACS trains surgeons in 9 main specialties: Cardiothoracic, General Surgery, Neurosurgery, Orthopaedics, Otolaryngology Head and Neck, Paediatrics, Plastic and Reconstructive, Urology and Vascular Surgery.

Oversimplifying the Complex

Despite these changes, RACS is still concerned that the current proposed model has the potential to oversimplify an extremely complex mix of clinical, procedural and financial realities. By creating a location-based average for individual specialist fees, providing geographic comparisons and comparative indicators (inside and outside of those geographical locations) indicating if a specialist's fee is "low" or "high" creates a simply stated interpretation of the value of healthcare that may not take into consideration the complexity of the patient, multidisciplinary care requirements, urgency of surgical procedures, variations in the procedure being performed, infrastructure or surgical skill among other factors.

RACS is inherently concerned about the "higher/lower than average" indicators discussed during the Forum as not being viewed as clinical indicators but rather as a de-facto value judgement. For instance, when looking at the average fee charged by a surgeon who operates on a highly complex patient requiring revisionary surgery with significant comorbidities, one would expect it to be higher than that of a surgeon who performs an uncomplicated procedure. The use of comparative indicators based on average fees between surgeons performing different surgical procedures may risk inadvertently penalising complexity, the distortions of referral patterns caused by an emphasis on average fees, a disincentive for surgeons to accept higher risk patients, and pressure to create procedural standardisation that is inconsistent with patient-centred care.

Other Concerning Health Economic Factors

RACS remains concerned that these transparency measures may hinder patients from receiving informed financial consent that is clinically specific to the patient’s needs. We observe that there is a distinction between price transparency and affordability, with the Consumer Health Forum suggesting

that just because you see how much something costs does not mean that you can afford to pay for it. This distinction is critical in addressing the underlying determinants of affordability in the healthcare system, including, but not limited to, rising hospital costs, shortages of the labour workforce, insurance design, declining sustainability of the private health insurance system, under-indexation of the MBS, indemnity pressures and increasing the complexity of surgical care.

RACS Supports Fee Ranges

The proposed structure of using fee ranges as opposed to stating a specific fee by the Department is a better option than a fee structure with only one indicative fee. The use of ranges better represents the potential variability found within clinical care, and it reduces the risk of any misleading impression being created as to what the expected costs will be. While RACS is supportive of the use of fee ranges rather than fixed fees, the College is still wary about how the methodology supporting the determination of these fee ranges has been developed, and whether the datasets used for the aggregation of fee ranges have been normalised in such a way that the complexity of procedures can be accurately represented.

Fee Range and Procedures

There were a few questions raised about the methodology that supports fee range during the Forum. They were about how bilateral procedures differ from unilateral procedures, and about procedures being performed on multiple tissues, or in combination with other procedures, and how to effectively differentiate between initial and follow-up procedures that were performed at different levels of complexity.

Procedurally episodes are not necessarily directly comparable and therefore similarly priced but share commonalities since they are performed on a common Medical Benefit Schedule (MBS) item number. There will continue to be variations due to other factors beyond the patient and the procedure, e.g. patient anatomy, urgency, revision surgery, obesity, frailty, as well as oncology complexity, complications, multidisciplinary involvement, prostheses, operating room times, regional workforce limitations, hospital capabilities, and others not completely captured, accounted for or reported in routine administrative billing datasets. Additionally, consumers may also misinterpret the indicative fee ranges as being representative of episodes that contain standardised or equivalently performed services.

Lack of Geographic Context and Privacy

The RACS continues to express concerns regarding geographic granularity and releases at a postcode and local area level. Although consumers would typically prefer to have location-based data available, the Department has acknowledged that there are increased privacy risks and identification risks associated with more granular (as opposed to less granular) data provided to the public (e.g., doctor, location, insurer) or with the release of low volume procedures. Surgeons who practice in smaller jurisdictions, highly specialised fields of surgery or in regional practice settings may be easily misinterpreted, subject to reputational damage and/or subject to inadvertent identification in a cohort of patients. These risks may be exacerbated in the longer term due to the increased ability to link to external datasets.

Post Operative Care

RACS also urged that the Department must understand that published procedural fees include much more than just the technical act of doing surgery, as well as being much larger than would normally be assumed. Administrative database and providing for numerous phase(s) of post-operative(s) care are often outside of the time and category of procedure. The Medicare Benefits

Schedule (MBS) generally contemplates that surgical fees are inclusive of routine post-operative care for up to 6 weeks from the date of surgery. However, many surgical specialities will provide care for far greater periods than 6 weeks from the date of surgery as part of the fee charged for the surgical procedure itself. Additionally, in several surgical disciplines, the expectations of the patient and the generally accepted professional practice behaviours involve months of ongoing review, nursing support, allied health coordination, recovery management, and where clinically indicated, provision of additional surgical procedures to revise the previous surgery.

For example, post-operative care can last anywhere from 6 months to 12 months after a plastic surgeon's original surgery, because there are many things that need to be followed up on (scar management, minor revisions, wound care, follow-up appointments, etc.) after a surgical procedure even if there are no complications. These services make up a large and often unreimbursed portion of the total cost of specialty services provided by plastic surgeons. As a result, if these procedural fees are published without taking into account the length of time and the scope of the post-operative care that is included with each procedure, it could make practitioners and procedures/sectors look like they provide completely different levels of treatment, when they actually provide the same overall level of quality.

RACS recommends that the department include explanatory information in the Medical Costs Finder that indicates the fees charged for procedures may include several aspects. These would include all or part of the episode of care that is not just a procedure, and that it would provide consumers with some sort of context around how long the period of time and what is included in post-operative care and also regarding any type of surgical revisions that were included with the initial cost of the procedure. Providing this information will assist consumers to provide informed financial consent to the hospital before having surgery and assist consumers in understanding that any differences in costs of procedures may be due to more than the procedure itself.

Annual Data Updates, Lag, and Review

There are also ongoing concerns about the proposed annual refresh cycle. While annual updates would improve the statistical reliability and the volume of data made available, the lag time between the date on which a physician bills and the date on which data is actually published could allow stale or non-representative data to remain highly visible for prolonged periods of time. For example, it is not uncommon for there to be material changes in a surgeon's practice, i.e., changes in the type of patients, insurers or types of procedures performed or fees charged, that would not be reflected for an extended period after the actual change occurred. For these reasons, RACS encourages the Department to ensure that any information provided to the public as "last updated" is prominently displayed and that specialists be provided with timely opportunities to view, correct and contextualise any data published by the Department before such data is released publicly.

RACS appreciates that the Department plans to create an internal review system based on administrative law principles and will provide an explanation of their methods for calculating rates as well as examples of how they come up with rates.
Nonetheless, to ensure the review system is effective and trustworthy, it must include transparency, fairness in conduct, responsive to all inputs, natural justice when a mistake has been made, and engagement with professionals in a meaningful fashion. As part of the process, specialists ought to receive enough supporting data to determine how the average figures were generated, including the MBS item combinations, number of samples used, rules for suppression, geographical assumptions of the insurers and how to combine the procedures.

RACS requests the Department provide stakeholders with an overview of the methodology, including data and data sources as part of the consultation process.

RACS Recommendations

RACS believes that specialists should be given the opportunity to request a review of published data if one or more of the following applies:

1) The published material is materially inaccurate or misleading.
2) The procedural classification does not accurately reflect the procedure's complexity.
3) There are concerns about data suppression, small sample size distortion, etc.
4) The data from an insurer or hospital is incomplete and/or unrepresentative.
5) Combined procedures were incorrectly interpreted, and/or

Additionally, RACS believes that the review process should include:

1) Clear timelines for communication.
2) Notifications prior to publication.
3) Opportunities for specialists to provide contextual information/explanations.
4) Procedures for escalation if there is still disagreement after the review.
5) Independent oversight and/or auditing of the procedures used and governance structure of the review.

RACS has supported the introduction of a single profile page per specialist together with a free text field so that specialists can provide contextual information that could enhance consumer understanding if done correctly. However, it is important that the contextual field does not replace robustly considered methodological protections.

RACS has proposed that the contextual information about specialists could include:

- The specialist's scope of practice, including any subspecialty;
- The complexity of surgery or revision surgery being performed by the specialist;
- The hospitals where the specialist has privileges and affiliations;
- The mix of public and private practice for the specialist;
- The languages spoken by the specialist;
- The availability of telehealth services from the specialist;
- Participation in the gap scheme;
- The nature of the multidisciplinary care provided by the specialist; and
- General information regarding the informed financial consent process.
- Provide greater detail to consumers regarding how they might receive financial consent prior to being billed by their treating surgeon.
- Provide some idea of how much they would need to pay should they require further treatment or have issues after surgery.

Additionally, it is essential that the website makes clear to all users that:

- The estimated fees are indicative only, and therefore should not be considered a quote;
- Costs for any individual will vary significantly due to variations in their individual circumstances;
- Lower fee structures do not equate to lower levels of expertise or quality of outcome or level of complexity of each procedure;
- All patients should discuss their own cost with the treating specialist; and
- The clinical appropriateness and quality of care provided by each specialist must be paramount when making any health care choice.

RACS encourages the Department of Health to make sure there are no unintentional consequences of the new MCF system that could detract from current patient information systems, referral pathways or the process of informed consent that already exist in both a professional and collegiate manner. Specialist profiles may also have similarities to current "Find a Surgeon" features. However, it should

be emphasised that the MCF does not replace clinically driven referral pathways, or credentialing systems that identify qualified specialists.

RACS remains concerned that the current reform agenda is placing too much policy emphasis on practitioner fee visibility, with much less emphasis placed on the broader structural cost drivers of the health system. Numerous factors will contribute toward creating out-of-pocket costs, including but not limited to the interactions between insurers and hospitals; the costs of the prescribed list; labour shortages; operating room costs; the costs associated with indemnity coverage; and/or pressures from the public and private systems. Therefore, reforms focused on transparency must form part of a wider health system strategy which encompasses sustainability, access, affordability and quality, rather than solely focusing on the visibility of practitioner fees.

Conclusion

The Royal Australian College of Surgeons (RACS) is worried that if the Government's reform framework becomes known publicly as a reduction of the complex challenges of the health system into a fee-for-service narrative of specialists, this could have far-reaching and unintended ramifications. With citizens increasingly losing faith globally in institutions (e.g., healthcare), any public messages (in particular those that could appear to politicise health care or damage confidence in Australia's specialist workforce) will compound the erosion of the public's trust in both clinicians and the health system.

There are far-reaching public health consequences for the erosion of trust in clinicians and established health institutions, including driving patients to non-regulated sources of health information such as social media, "influencers", or artificial intelligence chatbots, where misinformation and non-evidence-based advice is becoming even more prevalent. The erosion of public trust in clinicians and established health institutions may ultimately impair the governments' and health authorities' ability to mount co-ordinated public health responses to future crises such as vaccination campaigns or emergency health interventions as we have witnessed during the more recent global pandemic crisis.

RACS is once again expressing its concerns about the impact of transparency on procedural complexity, multi-specialty care and geographic location, as well as the inherent variation of patients' acuity associated with different types of services delivered by different providers. This has implications for the way that hospitals and surgical services are funded in that hospitals and surgical services are continuing to receive funding for the delivery of complex care as opposed to funding for routine services. This is because there will be no distinguishable difference between a complex procedure delivered to a patient as opposed to a routine procedure delivered to a patient when one compares the publicly available data associated with the delivery of that care.

As the number of surgeons is also adversely impacted by the existing surgical workforce shortage, the increasing pressures from legal claims against a surgeon and the increasing operating costs, the implementation of policies perceived as punitive, that have a negative impact on one's reputation and/or that are procedurally unfair will further lead to the loss of surgeons that perform high-risk, revision and/or resource-intensive procedures. This may well create an even more significant negative impact on the surgical workforce and making it increasingly difficult to recruit and retain highly skilled non-generalist non-GP specialist within Australia.

Therefore, RACS strongly recommends that the Department work towards ensuring that the finalised framework places emphasis on accurate, contextualised, procedurally just and shared government accountability in relation to the interpretation, governance and consequences of publicly available data. RACS remains committed to working collaboratively with the Department and continuing

dialogue as the methodology for developing the data collection, any resulting arrangements for the governance of the data collected and the development of review processes will be established.

Yours sincerely,

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President
Royal Australasian College of Surgeons

CC: Stephanie Clota, Chief Executive Officer, Royal Australasian College of Surgeons