

Specialists' fees and out-of-pocket costs: a challenge of our time

Medical practitioners consistently feature in the Australian Taxation Office (ATO) list of the top ten highest taxable incomes in Australia (Box 1). In the 2021–22 data, five of the top six average taxable income groups were medical practitioners, with incomes ranging from \$255 000 to \$460 000, noting that these are incomes after the deduction of costs related to the earning of the income.

Doctors have, not unreasonably, had an expectation of earning high incomes, given the training required for each specialty fellow. However, these incomes, and the fees that generate them, have created a number of challenges. The disparity between the income of specialist general practitioners and other specialists is unjustifiable and increases the relative unattractiveness of general practice.¹ For patients receiving specialist care from non-general practitioner specialists, the continued rise in out-of-pocket (OOP) costs is causing significant financial and access problems.^{2,3}

It is this latter issue, fees and OOP costs for non-general practitioner specialists (hereafter referred to as specialists) that I wish to explore. In 2018, I chaired a Ministerial Advisory Committee into OOP costs. A number of challenges and potential solutions were discussed by the committee, with an initial approach focused on transparency of fees to promote choice and competition.⁴ Although there has been improvement in the visibility of aggregate fees and OOP costs (through the Medical Costs Finder website), improvements in individual specialist fee transparency have been slow and there are calls for further intervention.

The reflections in this article are not intended as a criticism of most medical colleagues who are rationally responding to pressures and drivers, albeit sometimes without as much consideration for consumers as would be ideal.

Looking back

It is helpful to consider some history. When Medicare was introduced in 1984, general practice was not a recognised specialty and was accessible to any doctor with general registration.⁵ There were fewer specialists than general practitioners. Most specialists' consultations consisted of opinions and recommendations for management with ongoing management sitting largely with general practitioners. The limited number of specialists were in high demand and often worked very long hours (unacceptable by today's standards), with a significant proportion working more than 65 hours a week.⁶

In the early days of Medicare, these specialists earned high incomes, in part because of the hours they worked, but with fees or copayments that were

generally affordable. Medicare always envisaged a copayment, with the rebate set at 85% of the schedule fee for non-admitted services. Doctors entered specialist practice as soon as 12 years after school, without education debts. There was little anxiety about getting into advanced training programs, once entry examinations were passed.

The now

What has changed:

- Medicare Benefits Schedule (MBS) indexation has fallen behind cost-of-living increases (during the Medicare rebate freeze [2014]) and behind the increase in costs of running a private practice.⁷
- Specialists enter private practice later, having commonly completed two degrees before specialist training and having sometimes waited for an advanced training position.
- Most young specialists start practice with significant education debts and, because of their later age, will often have a family/mortgage etc.
- From discussions with specialist groups, it is clear that most of the current generation are not prepared to work 65 plus hours a week, nor does anyone consider it reasonable for them to do so.
- There are many more specialists and therefore no imperative for such long hours (in most specialties).
- Anecdotally, many general practitioners report that specialists, now in relatively greater supply, are more likely to seek to review patients with a chronic disease, when previously they would provide an opinion and advice to the general practitioner regarding ongoing management.

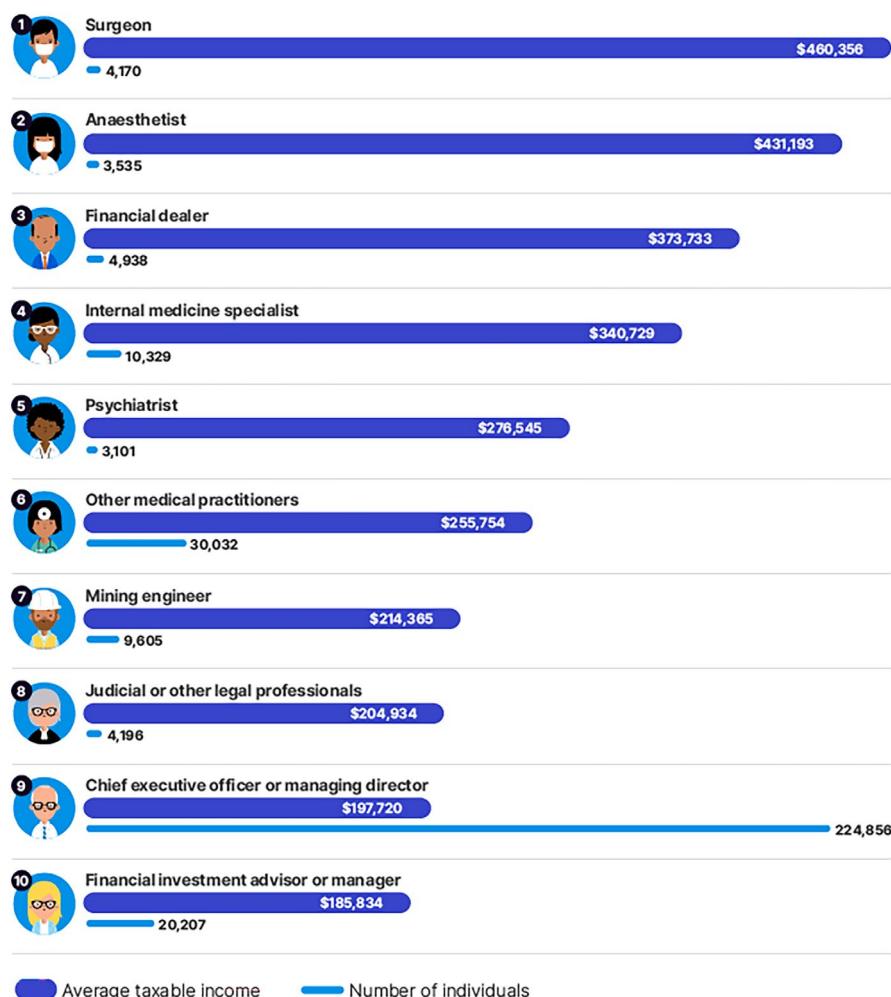
These changes have directly and indirectly driven an increase in specialist fees. Specialists have increased fees not only to cover the increased costs, but also to maintain parity with the higher incomes and matching lifestyles of their older role models. Box 2 shows that between 2010–11 and 2021–22, the taxable income of medical practitioners increased by 35–70%, during a period when consumer price index (CPI) growth was only 27%.⁸ Despite the changes in clinical practice (fewer hours, more review consultations, etc), specialists feel that they are making the same commitment as their role models, often in a more technically advanced way, and, accordingly, feel a strong sense of entitlement to the same level of income. To achieve this desired income maintenance and growth, specialists have increased fees beyond the rate of MBS indexation and CPI. For example, the average OOP gap payment applicable to specialist attendances increased from \$49.56 in 2010–11 to \$117.18 in 2023–24.⁹ This equates to a 136% increase in OOP gap payment in a period over which there was a 40% increase in CPI.⁸ A recent report by the

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1 Top ten average taxable incomes by profession for the 2021–22 financial year



Source: Australian Taxation Office (<https://www.ato.gov.au/about-ato/research-and-statistics/in-detail/taxation-statistics/taxation-statistics-2021-22/statistics/individuals-statistics>), used with permission. "Specialist general practitioners" are included in the category of "Other medical practitioners". ♦

2 Increase in taxable income (\$) for medical practitioners between 2010–11 and 2021–22

	2010–11 taxable income	2021–22 taxable income	Percentage increase
Surgeons	\$341 610	\$460 356	35%
Anaesthetists	\$299 835	\$431 193	44%
Internal medicine specialists	\$249 012	\$340 729	37%
Psychiatrists	\$171 982	\$276 545	61%
Other medical practitioners	\$150 717	\$255 754	70%

Source: Australian Taxation Office (<https://www.ato.gov.au/about-ato/research-and-statistics/in-detail/taxation-statistics/taxation-statistics-2021-22/statistics/individuals-statistics>). ♦

Grattan Institute showed that, for all specialist fees (including items other than attendances), the average gap payment has increased by a smaller but still significant 73% since 2010.³

Many specialists now charge multiples of the MBS schedule fee for consultations and, for inpatient services, fees are sometimes thousands of dollars more than the schedule fee.¹⁰ Most specialists will have a reduced fee schedule for concessional patients, but even these will often have significant copayments.

Some specialists, when defending their incomes and fees, will point to other professions, such as barristers, where a proportion charge even higher fees than the medical specialists in question. But lawyers fall well below all the doctor groups in the ATO top income chart for a simple reason. Although many lawyers can earn extremely high incomes, the market for legal services is competitive and the income distribution profile is broad. The highest earners will not be able to command high fees unless they are seen to offer a differentiable service and outcome.

A competitive relationship between expertise and ability to command high fees is generally not apparent in medical specialties,⁴ where fees (and subsequent incomes) of a specific group of medical specialists tend to be similar in a geographic area, regardless of experience or expertise.¹¹ Commonly, an older, experienced specialist will charge less than their younger counterparts.

It is important to consider inpatient and outpatient medical fees separately. Most patients who are charged inpatient fees are privately insured.¹² The insurers have sought to maintain value for their products by insulating patients from OOP costs with “no gap” or “known gap” products. Recently, some insurers have explicitly developed low cost models of care, such as short stay arthroplasty,¹³ actively limiting exposure to specialist OOP costs. These actions by insurers have blunted the impact of OOP costs on patients but have shifted the cost burden into increased premiums.¹⁴

In the outpatient setting, the Australian Government has attempted to mitigate the impact of OOP costs by introducing Medicare safety nets (Original and Extended Medicare Safety Nets). Although these have provided some relief, the Extended Medicare Safety Net (EMSN) has been inflationary¹⁵ and required additional caps to be put in place to limit further fee escalation. Despite these safety nets, for low income patients requiring frequent specialist consultations, the OOP costs have become a barrier to seeking care or a reason to seek care in the overcrowded public hospital system.^{2,3} This, sadly, is a failure of one of the original aims of Medicare, that even uninsured people could access private outpatient care with an affordable copayment.

An additional consequence of the relatively high incomes of private medical specialists is the impact on the public hospital system. Even quite high salaries (by community standards) being offered in the public system are not competitive with the salaries that can be achieved in many private practice settings.

The impact of medical specialist fees on the cost of living and access to care is such that calls for some form of policy intervention will increase.³

Looking forward

Doctors argue that to fix this imbalance, the most important thing is to increase the Medicare rebates across the board to compensate for the previous freezes and other costs of practice.⁷ It is proposed that some of the funds for this, in consultation fees, could come from additional caps or limits on the EMSN. There are two main problems with this. The first is that the priority for any new investment in Medicare has to be in primary care, reducing the income differential. This is essential to strengthen general practice and make it a specialty of choice for doctors. Recent Medicare investments (such as the triple bulk-billing incentive) have rightly been in general practice. Additional investment in specialists is harder to justify when incomes are high. The second problem is that initiatives to increase patient rebates have a history of being inflationary and are associated with further

fee increases, thereby reducing the benefits realised by patients. This was seen following the introduction of the EMSN.¹⁵ An increase in MBS fees for specialist consultations (arguably where MBS fees are most insufficient) would need some form of prior agreement to prevent doctors from further raising fees and potentially further reducing their working hours.

In the admitted patient context, private insurers will continue to grow lower cost models of care.

There remains an argument that the MBS is unbalanced, with some procedures overvalued and consultations undervalued.¹⁶ This could only be addressed comprehensively by another “Relative Values” review of Medicare. Although governments have been prepared to undertake slow and careful MBS reform, a full-scale rebalancing of the MBS probably requires a level of political courage that might be hard to find!

There is value in further pursuing the transparency approach initiated by the Ministerial Advisory Committee into OOP costs.^{3,4} Although the Medical Costs Finder website displays aggregated costs per specialty/item/region, individual doctor costs have been disappointingly slow to appear. Without the ability for patients to compare the fees charged by specialists, before making the initial appointment, competitive pressures will not be realised. Given the slow uptake by individual specialists, there is an argument that some form of compulsion to provide fee transparency (before initial contact) should be introduced, such as by making this a requirement to access a provider number. Most specialists are transparent with fees after the initial appointment is made, but this next step would enable patients and their referring general practitioners to compare fees before making an appointment. Even better would be the inclusion on the individual specialists’ websites, of evidence of advanced skills and experience that might justify higher fees.

If the current reform of primary care is successful and general practitioners and their teams are better able and available to manage chronic conditions in the long term with less specialist input, this could improve the business model of specialist practice, with a shift back to a greater proportion of initial consultations.

Potential fee regulation¹⁷ is argued for on the basis that access to medical care is a fundamental right and is highly subsidised by government. Constitutional limitations on civil conscription are seen by many to prevent any form of regulation, which would be subject to legal challenge. Others argue that it is time to test this limitation, given the importance of this issue to society more broadly.¹⁸ An alternative to direct fee regulation would be to deny MBS benefits for excessive fees.³ However, MBS benefits are a patient benefit and it would be hard to deny the benefit to patients if a doctor did charge a fee higher than the limit.

Self-regulation is the simplest option. Given the community and government angst about this issue, specialists would do well to reflect on the impact of their fees on patients and potentially consider a minor

trade-off in income in recognition of the now improved working hours. A voluntary acceptance of this trade-off would improve patient access and reduce the risk of government intervention. Better discernment on the capacity of patients to pay is required. While wealthy retirees may be able to afford substantial fees, recognition of the financial impact of ongoing specialist care to people with limited/fixed income and chronic disease would be welcome, as would some ethical reflection on the effect this has on equity of access to health care.

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