

Inquiry into access to and affordability of medical specialists in Australia

Bupa Submission

Bupa Australia

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About Bupa

Bupa is an international healthcare group which has been committed to a purpose of helping people live longer, healthier, happier lives and making a better world for more than 75 years.

Bupa Australia supports customers through a broad range of health and care services including health insurance, aged care, dental, medical, optical and hearing services.

Bupa Health Insurance has one of the largest hospital networks in Australia, providing high-value cover to 4.5 million members.

Bupa Health Services operates 34 medical centres (including four Urgent Care Clinics), 17 mental health clinics, over 170 dental clinics, and 48 optical and hearing stores. These health services are open to everyone, not just Bupa Health Insurance customers. We also partner with the Australian Government to deliver visa medical checks to migrants, and health services to Australian Defence Force personnel and veterans.

Bupa Villages and Aged Care is one of Australia's largest aged care providers offering a wide range of residential aged care services. As a trusted care provider, we currently operate 57 residential aged care homes across four states, employing around 7,000 team members and caring for more than 5,500 residents.

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Executive Summary

Access to timely and affordable specialist care is becoming increasingly challenging for many Australians. Workforce shortages and geographic maldistribution are contributing to delays in diagnosis and treatment. Rising out-of-pocket costs, limited fee transparency and fragmented referral pathways are increasing pressure on patients, primary care providers, and the broader health system. These challenges are often most acute in rural and regional communities. Bupa welcomes the opportunity to provide a submission to the House Standing Committee on Health, Aged Care and Disability's *Inquiry into access to and affordability of medical specialists in Australia*. As both a health insurer and healthcare provider, Bupa sees the impact of these challenges across the patient journey.

In 2025, Bupa supported more than 1.13 million inpatient episodes and nearly 4.93 million specialist medical services through more than 37,600 specialist-provider relationships across 34 specialty categories. This demonstrates the critical role that specialists play in member access to care. At the same time, Bupa claims data highlights the growing affordability pressures, with total member out-of-pocket costs increasing by more than 28 per cent between 2023 and 2025 despite inpatient episodes rising by only three percent.



Bupa believes that patients should have greater transparency and choice at the point of referral. Patients should be able to compare public and private specialist waiting times and understand their likely out-of-pocket costs before deciding where and how to access care.

Bupa maintains that specialist access and affordability cannot be addressed through workforce growth alone. Increasing specialist supply remains essential, but it must be accompanied by reforms that improve transparency, strengthen consumer protections and redesign care pathways so specialist expertise is directed to patients with the greatest clinical need. Bupa recommends that the Government focus on three key areas:

1. **Strengthening specialist workforce capacity and distribution** through coordinated workforce planning, targeted training pathways and stronger regional employment opportunities.
2. **Improving affordability, transparency and informed patient choice** through stronger informed financial consent, greater visibility of specialist costs and waiting times, and improved access to public and private care options.
3. **Supporting innovative models of care**, including GP-specialist consultation services, shared care, virtual care and modern referral pathways that improve access and make better use of specialist expertise.

We are committed to supporting these objectives through initiatives that improve affordability and access for Australians, and by contributing our knowledge as both an insurer and healthcare company. However, many of the challenges identified in this submission require coordinated action across the health system. Taken together, these reforms would help more Australians access timely and affordable specialist care, improve patient experience and strengthen the sustainability and effectiveness of Australia's mixed public and private healthcare system.

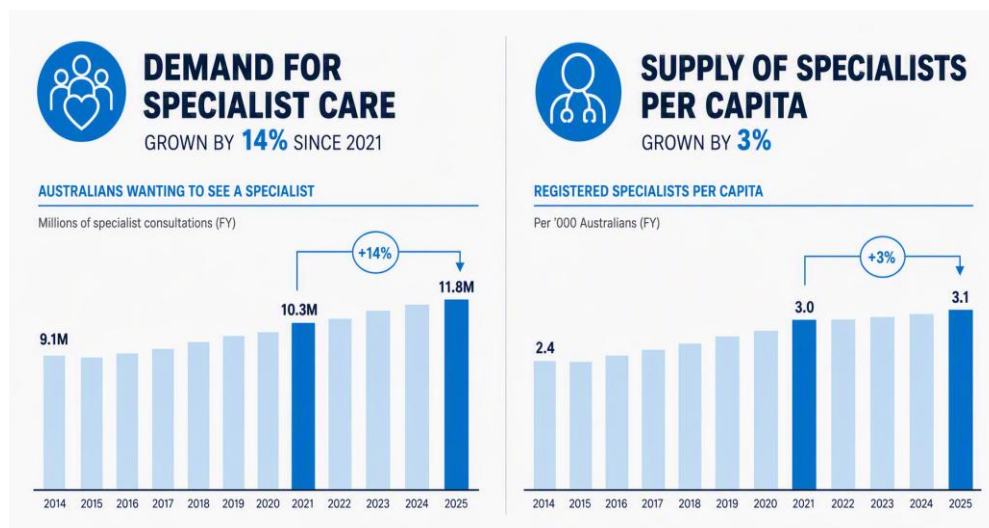
Summary of recommendations

Part 1: Challenges in specialist access	
Recommendation	Actions
National specialist workforce planning agency	Government should establish a national specialist workforce planning agency within the Department to ensure the private system is optimised and working efficiently alongside the public system. This includes setting need-based training targets, coordinating system partners, and publish a workforce framework and dataset linking training supply to demand, access and waiting times.
Expand and better target the domestic specialist training pipeline	Government should create a nationally coordinated pool of funded training positions targeted to shortage specialties and locations, supported by supervision, regional pathways and training infrastructure.
Streamline pathways for internationally trained specialists	Government should streamline recognition and registration for suitably qualified international specialists in shortage areas, while maintaining standards and domestic workforce investment.
Expand regional training and employment pathways	Government should expand regional and rural pathways through more accredited positions and secondments, stronger supervision and rural generalist pathways, substantial regional training and links to ongoing employment.
Part 2: Improving affordability of specialist care	
Recommendation	Actions
National no-surprise billing framework	Government should standardise informed financial consent, require upfront estimates of foreseeable specialist and hospital costs, and limit liability where disclosure requirements are not met, with emergency safeguards.
Modernising referral arrangements	Government should modernise referrals so patients can readily choose another specialist when cost, availability or waiting times are barriers.
Ensure MBS rebates are adequately indexed	Government should index MBS rebates in line with appropriate inflationary indexes, such as the health inflation index.
Improve specialist fee transparency and patient choice	Government should expand the Medical Costs Finder to show fees, waiting times, gap participation and expected out-of-pocket costs, backed by nationally consistent publication of indicative private fees.
Improve access to publicly funded specialist services	Government should expand public outpatient capacity where unmet need is greatest, publish waiting times and referral outcomes, and scale telehealth, outreach and other access models.
Strengthen oversight of specialist markets	Government should conduct regular ACCC and Department reviews of specialist pricing, competition and billing, publishing trends in out-of-pocket costs, fee variation and market concentration.
Part 3: Innovative models to improve specialist access	
Recommendation	Actions
National GP-specialist consultation service	Government should fund national GP-specialist secondary consultations and shared care so GPs can obtain advice without unnecessary face-to-face referrals, preserving specialist capacity for greatest need.
Expand integrated virtual specialist care and outreach networks	Government should expand integrated virtual care, telehealth and outreach, particularly outside metropolitan areas, so patients can access specialist expertise closer to home.
Progress HITH and virtual ward programs	Government should scale Hospital in the Home and virtual wards to avoid admissions, support earlier discharge, increase effective specialist capacity and improve patient outcomes.
National interoperable digital referrals	Government should establish interoperable digital referrals supporting triage, Requests for Advice, status tracking and secure information sharing across primary care, specialists and hospitals.

1. Challenges in specialist access

Current system challenges

Australia's ability to provide equitable access to specialist care is constrained by two interrelated workforce challenges, an insufficient pipeline of specialists and an uneven geographic distribution of the available workforce and facilities. While Australia has increased the number of medical graduates and expanded parts of the health workforce, these gains have not translated into sufficient specialist capacity to meet growing demand.



Source: ABS, *Patient Experiences, 2024-25 Financial Year*; ABS, *National, State and Territory Population, March 2026*; Medical Board of Australia, *Registration Data Table - June 2026*, Mandala Partners analysis for Bupa – July 2026.

An ageing and growing population, combined with the rising prevalence of chronic and complex conditions, is increasing demand for specialist services faster than the workforce can grow to meet it. At the same time, specialist capacity remains concentrated in major metropolitan centres, leaving many regional, rural and remote communities with limited access to timely care. Together, these challenges contribute to longer wait times, reduced patient choice and widening inequities in access to specialist services.

1. Specialist supply

As noted in Bupa's recent discussion paper, [Building a More Accessible, Modern and Sustainable Health System](#), national modelling projects a shortfall of 6,981 full-time-equivalent specialists by 2033, rising to 12,812 by 2048 under current settings.¹ The pathway to specialist qualification typically takes 12 to 16 years and depends on sufficient teaching capacity, clinical placements, supervision and accredited training positions. Increasing medical student numbers alone will therefore not address future shortages without corresponding investment across the specialist training pipeline.²

The most significant constraint is progression from prevocational employment into accredited registrar and specialist training. Competition for positions substantially exceeds capacity in several specialties. Currently, there are an estimated 12,300 unaccredited trainees in Australia with only 34 per cent of surgical college applicants successful in 2024.³ This has contributed to a growing cohort of doctors

¹ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 3.

² Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 4-5, 25-26.

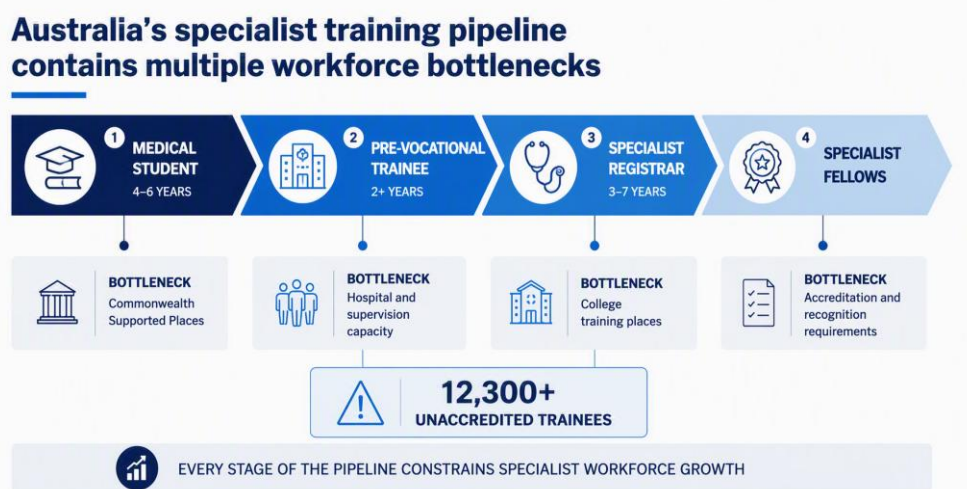
³ Analysis by Mandala Partners for Bupa – July 2026. Calculated from Medical Board of Australia and Australian Health Practitioner Regulation Agency, [Medical Training Survey 2024 Report](#) (Report, 2025); Medical Board of Australia, [Registration Data Table – March 2026](#) (Report, 1 June 2026); Dowling, Caroline et al, 'Unaccredited Specialty Surgery "Training": The Impact of the Years Prior to SET Entry' (2026) 96(4) *ANZ Journal of Surgery* 717

working in unaccredited registrar roles without the structured education, supervision or defined progression available through accredited programs.⁴



Source: Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (June 2026); Mandala Partners analysis for Bupa – July 2026.

Under current projections, the surplus of prevocational doctors will increase from 8.7 per cent in 2025 to approximately 28 per cent by 2033.⁵ At the same time, the proportion progressing to registrar training is projected to fall from 36 per cent in 2024 to 15 per cent by 2048.⁶ This indicates that the principal bottleneck is not the number of medical graduates, but the availability and distribution of accredited specialist training opportunities.



Source: 8% of total doctor workforce reported as “unaccredited registrar” Medical Board of Australia (2025) Medical Training Survey national; total 153,226 registered medical practitioners from Medical Board of Australia (2026) Registrant data. 2. ANZ Journal of Surgery (2026) Unaccredited Specialty Surgery “Training”: The Impact of the Years Prior to SET Entry. Mandala analysis 2026.

Workforce governance is also fragmented across governments, health services, universities, specialist colleges, regulators and accreditation bodies. Decisions about medical school intake, hospital employment, training accreditation and workforce distribution are made through separate processes with different objectives and timeframes. No single body has responsibility for aligning these settings with projected community need.⁷

⁴ Jerome Martin Laurence, ‘Unaccredited Medical Training in Australia: From Hidden Problems to Practical Workforce Solutions’ (2026) 56(6) *Internal Medicine Journal* 1091 4.

⁵ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 19–20.

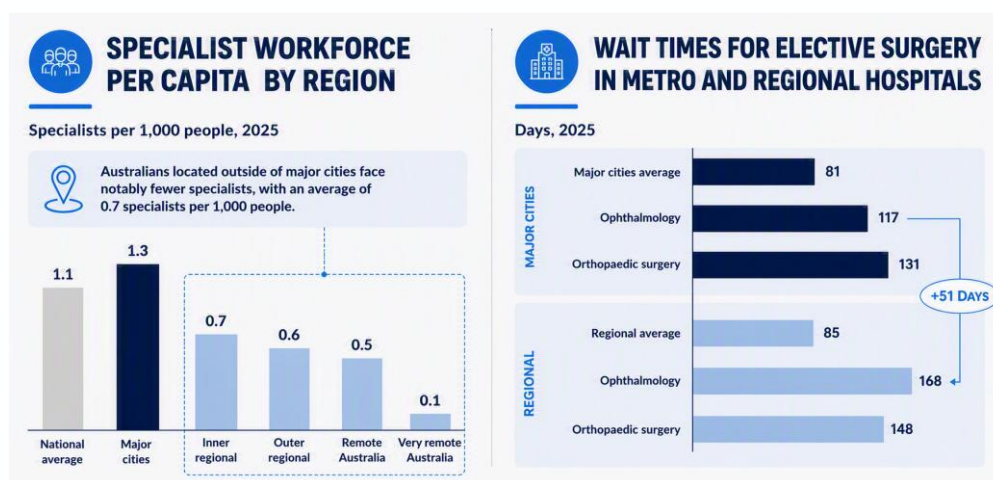
⁶ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 21.

⁷ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 26.

Australia also relies heavily on internationally trained doctors, who now outnumber domestic graduates entering the medical workforce each year.⁸ Registration, assessment and supervised practice requirements remain essential to patient safety, but unnecessary delays can restrict the timely deployment of qualified clinicians to areas of need and the career progression of Australian doctors. International recruitment should continue to support the workforce, but it cannot replace sustained investment in domestic training, distribution and retention.⁹

2. Workforce distribution

Existing specialist capacity is concentrated in metropolitan centres. Remote areas have approximately seven times fewer specialists than major cities, despite experiencing a higher burden of disease.¹⁰ Specialist workforce density falls by more than half outside major cities and is over 90% lower in very remote Australia, highlighting the significant geographic maldistribution of specialist care.¹¹



Source: Calculated from Department of Health, Disability and Ageing, [Health Workforce Dataset](#) (2026); Australian Bureau of Statistics, [Estimated Resident Population, Local Government Areas](#) (2026); Mandala Partners analysis for Bupa – July 2026

Major cities contain most tertiary hospitals, specialist practices, supervisors and accredited training positions. Regional centres provide essential services to much larger rural catchments but generally have less workforce depth. Shortages are evident across specialties including psychiatry, oncology, general medicine, dermatology and paediatric surgery.¹² In 2025, regional waiting times for ophthalmology and orthopaedic services were approximately 30 to 50 days longer than in major cities. In areas with limited local capacity, patients may need to rely on visiting services or travel long distances, incurring accommodation and travel costs and time away from work or caring responsibilities.¹³ They may also lack family or other support during their health episodes.

Regional shortages reflect interconnected training, professional and community factors rather than remuneration alone. Key barriers include limited regional training opportunities, professional isolation, fewer opportunities for career progression and subspecialisation, uncertainty about ongoing

⁸ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 2.

⁹ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 2, 25-26.

¹⁰ Australian Institute of Health and Welfare, [Rural and Remote Health](#) (Web Page, accessed 1 September 2026).

¹¹ Calculated from Department of Health, Disability and Ageing, [Health Workforce Dataset](#) (2026); Australian Bureau of Statistics, [Estimated Resident Population, Local Government Areas](#) (2026); Mandala Partners analysis for Bupa – July 2026. The specialist workforce density reported in the source data is 1.3 specialists per 1,000 population in major cities, compared with 0.7 in inner regional areas, 0.6 in outer regional areas, 0.5 in remote Australia and 0.1 in very remote Australia.

¹² Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 2, 5, 8-9, 25-26.

¹³ Calculated from Department of Health, Disability and Ageing, [Health Workforce Dataset](#) (2026); Australian Bureau of Statistics, [Estimated Resident Population, Local Government Areas](#) (2026); Mandala Partners analysis for Bupa – July 2026. Weighted average number of days waiting for elective surgery by specialty and number of surgeries. Data for medium and large hospitals

employment, housing availability, partner employment, childcare access, workload pressures and barriers to taking leave.¹⁴

Building sustainable regional workforces requires locally based training and career pathways, supported by the professional and community conditions that help clinicians stay.¹⁵ For example, rural generalist pathways allow doctors to train, develop and secure continuing employment within regional communities. Retention is also influenced by workload, work-life balance, accommodation costs, childcare, career progression, access to professional development, strong community connections and alignment with broader career aspirations.¹⁶

Impact on patients and the health system

Workforce shortages and maldistribution reduce service availability, extend waiting times and limit patient choice.¹⁷ In 2024-25, 18.3 per cent of Australians aged 15 years and over who needed to see a specialist delayed or did not receive that care. More than one-quarter of people who saw a specialist reported waiting longer than they considered acceptable.¹⁸

Public elective surgery statistics do not capture the full period patients may wait for care. Before joining an elective surgery waiting list, a patient may wait for a GP appointment, referral and initial public outpatient specialist consultation. This period has been described as a “hidden waiting list” and can extend for months or years.¹⁹

Access pressures vary by specialty. A national study of psychiatric specialist appointments found that the average period between GP referral and first appointment increased from 51 days in 2011 to 77 days in 2022. The longest quarter of face-to-face waits exceeded 258 days, with regional and remote patients consistently waiting longer than patients in major cities.²⁰

The consequences extend beyond the delayed appointment. Patients may experience later diagnosis, prolonged symptoms and disruption to chronic disease management. General practice may also retain responsibility for monitoring symptoms and managing clinical risk while patients wait for specialist input.

Bupa's evidence and experience

1. Bupa practitioner survey

In June 2026, Bupa surveyed general practitioners (**GPs**), general practice nurses and practice managers working at Bupa Medical centres to understand the barriers patients face in accessing specialist care. A significant proportion of Bupa GPs reported that specialist distribution is inadequate and that difficulties accessing specialists affect their ability to provide timely care and contribute to delays in diagnosis and treatment. GPs identified shortages in psychiatry and paediatrics as key challenges. Many reported managing patients with complex health needs for longer than clinically desirable because of specialist shortages and lengthy public waiting lists. The impact on patients was

¹⁴ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 25-26; Catherine Cosgrave, Christina Malatzky and Judy Gillespie, 'Social Determinants of Rural Health Workforce Retention: A Scoping Review' (2019) 16(3) [International Journal of Environmental Research and Public Health](#) 314.

¹⁵ Russell, McGrail, Anthony Scott and James Humphreys, 'Increasing Doctors Working in Specific Rural Regions Through Selection From and Training in the Same Region: National Evidence From Australia' (2021) 19 [Human Resources for Health](#) 132.

¹⁶ Catherine Cosgrave, Christina Malatzky and Judy Gillespie, 'Social Determinants of Rural Health Workforce Retention: A Scoping Review' (2019) 16(3) [International Journal of Environmental Research and Public Health](#) 314; Rural Workforce Agency Victoria, [Victorian Rural Health Workforce Census 2024](#) (Report, 2025).

¹⁷ Department of Health, Disability and Ageing (Cth), [Whole of Medical Workforce Supply and Demand Compendium Report](#) (Report, June 2026) 25-26;

¹⁸ Australian Bureau of Statistics, [Patient Experiences, 2024-25 Financial Year](#) (Web Page, 18 November 2025) .

¹⁹ Australian Medical Association, [Shining a Light on the Elective Surgery "Hidden" Waiting List](#) (Report, September 2022).

²⁰ Ou Yang and Yuting Zhag, 'Wait Times for Psychiatric Specialist Services in Australia' (2025) 8(2) [JAMA Network Open](#).

substantial. One GP said that “delays in assessment and management can prevent patients from accessing care altogether”. Many GPs reported carrying greater clinical risk while patients await specialist assessment.

A similar picture emerged from nurses. Over 60 per cent of surveyed nurses reported that limited access to specialist services had delayed diagnosis or treatment while more than 60 per cent identified the lack of specialists practising in regional and rural areas as a significant workforce gap. Forty five per cent called for stronger initiatives to attract and retain specialists outside metropolitan centres.

Practice Managers reported similar concerns. More than 40 per cent rated overall access to specialists as “poor”, while 60 per cent considered the current distribution of specialists to be “inadequate”. Respondents identified long waiting times and limited specialist availability, particularly in paediatrics, psychiatry and dermatology, as major barriers to care. They reported that patients frequently need to travel significant distances or seek alternative providers to access treatment, creating delays in care and increasing administrative burdens on already stretched general practices.

The survey findings reinforce broader national evidence that improving access to specialist care requires action to both increase specialist workforce capacity and address its distribution. Reforms must strengthen the specialist training pipeline, improve regional workforce attraction and retention, and reduce access barriers so the workforce can better meet community needs.

“**Delayed treatment and symptom management leads to more severe unmanaged symptoms. Delayed care can have a mental and physical impact on the patient, as well as reducing confidence in the health system.**”



 **Bupa nurse**
Metropolitan clinic

“Often when a patient is unable to get in to see the specialist their GP has referred them to due to long wait times, the patient will call us back to advise us of this as they require a referral change. This results in disruptions to doctors, added disruption to already busy reception phones, and is inconvenient for the patient directly. Further, patients also have issues with significant wait lists when being referred to the public sector”



 **Bupa Practice Manager**
Metropolitan clinic

Recommendations Part 1: Challenges in specialist access

Recommendation	Actions
National specialist workforce planning agency	Government should establish a national specialist workforce planning agency overseen by the Department of Health, Disability and Ageing. The Agency should: • set and oversee delivery of nationally agreed specialty-level training targets based on projected need while colleges retain responsibility for curricula and clinical standards. • have a working group with representation from the Commonwealth, states and territories, public and private health services, universities, training organisations, regulators and communities. • develop a nationally consistent workforce planning framework and dataset (including public transparency) spanning medical school places through post-qualification employment, specialty trainees, non-specialist doctors fellows & supervisors, linked to demand and access indicators such as waiting times.
Expand and better target the domestic specialist training pipeline	Government should establish a nationally coordinated pool of funded specialist training positions sized and distributed according to workforce modelling, including dedicated investment in supervision capacity, accredited regional training pathways and training infrastructure in undersupplied specialties and locations.
Streamline pathways for internationally trained specialists	Government should expand and streamline specialist recognition and registration pathways for appropriately qualified internationally trained specialists in undersupplied specialties and regions, while maintaining standards and recognising international recruitment as a complement to domestic workforce growth rather than a substitute for it.
Expand regional training and employment pathways	Government should expand accredited specialist training, supervision and employment pathways in regional and rural Australia. Including: • Increasing accredited specialist training positions or secondment opportunities in regional and rural health services, particularly in shortage specialties. • Further promotion of rural generalist pathways. • Investing in regional supervision, teaching and mentorship capacity. • Support training pathways that enable doctors to complete a substantial proportion of specialist training in regional communities. • Align training and workforce planning initiatives to improve transition into ongoing regional specialist practice.

2. Improving affordability of specialist care

Current system challenges

Australia's specialist care system faces a growing affordability challenge. Rising out-of-pocket costs, limited transparency about fees and constrained access to publicly funded specialist services are making it more difficult for patients to obtain timely care. These pressures are particularly significant for people requiring multiple consultations, diagnostic investigations or ongoing specialist management.

1. Rising and cumulative out-of-pocket costs

Out-of-pocket costs are an established feature of Australia's mixed public and private healthcare system. However, rising medical fees and uncertainty about the total cost of treatment are making specialist care less accessible, particularly when patients cannot determine their likely financial liability before receiving care. Among patients admitted to private hospitals, 60 per cent reported paying an out-of-pocket cost and 70 per cent of those patients paid more than \$500.²¹ Thirty-seven per cent reported psychological distress associated with these costs, while one in five had skipped a specialist appointment or declined recommended treatment because of the expense.²²

Specialist care costs are often cumulative rather than limited to a single consultation. Patients may incur separate charges for initial consultations, diagnostic investigations, procedures, follow-up appointments, medicines and rehabilitation services. Consequently, the total cost of care can be difficult to anticipate at the outset of treatment. In 2024–25, 8.6 per cent of Australians who required specialist care delayed or did not access that care because of cost.²³ Cost pressures can therefore prevent patients from accessing clinically appropriate care and contribute to delayed diagnosis, delayed treatment and poorer health outcomes.

2. Access to specialists through public health services

Affordability is influenced not only by specialist fees but also by access to publicly funded specialist services. Patients who are unable to afford private specialist care frequently rely on public outpatient clinics, where specialist consultations are provided at no direct cost. While this reduces financial barriers, public outpatient services often face significant demand pressures, resulting in lengthy waiting times before specialist assessment.²⁴

For many patients, particularly those on lower incomes, affordability therefore involves a trade-off between the direct cost of private specialist care and the indirect costs associated with delayed access through the public system. These indirect costs may include prolonged symptoms, delayed diagnosis, lost productivity and ongoing visits to primary care providers while awaiting specialist assessment. As private specialist costs continue to rise, more patients may seek care through publicly funded specialist services, increasing pressure on already constrained public outpatient capacity.

²¹ Patients Australia and La Trobe University. [Patient View Report 2025](#). (2025).

²² Patients Australia and La Trobe University. [Patient View Report 2025](#). (2025).

²³ Australian Bureau of Statistics, *Patient Experiences, 2024-25 Financial Year* (Web Page, 18 November 2025)

²⁴ Australian Bureau of Statistics, *Patient Experiences, 2024-25 Financial Year* (Web Page, 18 November 2025)

3. Limited fee transparency constrains informed patient choice

Specialists have a legitimate role in setting their fees within a competitive healthcare market. For that market to work effectively, however, patients need clear, timely and comparable information about the likely cost and quality of care. Before commencing treatment, patients currently have limited visibility of specialist fees, participation in insurer agreement arrangements, waiting times, areas of expertise and likely out-of-pocket costs. We welcome the Government's reforms to the Medical Costs Finder, which will improve transparency for consumers, support more informed healthcare decisions, and help build greater trust in the health system. However, its effectiveness depends on the availability and completeness of the underlying data.

Although patients may technically choose their specialist, that choice is constrained when they cannot understand the financial consequences of selecting one provider over another. Seeking an alternative specialist may also require a return visit to their GP for a new referral, creating additional administrative burden, delay and cost.²⁵ In 2024-25, 18.3 per cent of Australians aged 15 years and over deferred or did not see a specialist when needed.²⁶ Cost was identified as a barrier by 8.6 per cent of respondents, while a further 9.7 per cent cited other barriers including waiting times and service availability.²⁷

Where specialist supply is limited, patients may have little practical ability to compare providers or choose a lower-cost alternative. In these circumstances, higher fees can become the default rather than the result of an informed choice.

4. Factors influencing specialist fees

Specialist fees vary considerably across specialties, procedures and locations. Fee differences reflect a range of factors, including:

- the complexity and duration of consultations and procedures
- workforce shortages and local supply constraints
- operating costs, including staffing, premises, technology and medical indemnity insurance
- geographic location and the availability of alternative providers
- participation in insurer agreement arrangements
- Medicare rebate levels and indexation settings and
- the extent to which patients can compare providers based on cost and quality information.²⁸

Many of these factors are legitimate influences on pricing. However, patients frequently have limited visibility of why fees differ between providers, making it difficult to assess value or compare options before commencing treatment.

²⁵ Australian Bureau of Statistics, *Patient Experiences, 2024-25 Financial Year* (Web Page, 18 November 2025)

²⁶ Australian Bureau of Statistics, *Patient Experiences, 2024-25 Financial Year* (Web Page, 18 November 2025)

²⁷ Australian Bureau of Statistics, *Patient Experiences, 2024-25 Financial Year* (Web Page, 18 November 2025)

²⁸ Mandala Partners (for Private Healthcare Australia), *Reducing Out-of-Pocket Costs for Australian Healthcare Consumers* (Report, 2025).

5. Significant variation in patient costs

PATIENTS FACE SUBSTANTIAL VARIATION IN SPECIALIST COSTS

Out-of-pocket costs for an initial specialist consultation vary widely across and within specialties.



Source: Department of Health, Disability and Ageing, *Medical Cost Finder* (2026); Mandala Partners for Bupa – July 2026., Analysis of specialist out-of-pocket costs for initial consultations.

Out-of-pocket costs are concentrated across several common procedures and vary substantially by location. For an uncomplicated hip replacement, the median out-of-pocket medical cost in FY2023 was approximately \$1,448.²⁹

Data from the Medical Cost Finder tool shows that patients who had an initial specialist consultation in 2025 typically paid \$147 in out-of-pocket costs, with 10 per cent of patients paying \$252 or more for a single appointment. Costs vary across and within specialties, from \$100-\$307 for an initial paediatric consultation, to \$173-\$503 for an initial psychiatry consultation.³⁰

Substantial geographic variation also exists. In the financial year 2023, the Australian Capital Territory recorded a median visible out-of-pocket cost of approximately \$591 per medical service, more than double the national median of \$240.³¹ As a result, a patient's financial liability may depend heavily on where they live, the procedure they require and whether their treating specialist participates in a gap arrangement with their insurer.

6. Existing arrangements do not consistently protect consumers from rising costs

Insurer gap schemes can reduce or eliminate out-of-pocket medical costs, but their effectiveness depends on voluntary specialist participation. Under a no-gap arrangement, the specialist accepts the combined Medicare and insurer payment as full payment; under a known-gap arrangement, the patient contribution is capped. Participation may vary between specialists, patients and episodes of care, leaving some patients exposed to higher and less predictable costs. No-gap schemes are not a complete solution because they rely on individual agreements and may not cover every clinician involved in an episode of care, including doctors providing unexpected or substitute cover.

This variability means neither arrangement provides a comprehensive solution to high out-of-pocket costs. However, known-gap arrangements offer the more practical outcome because they cap patient contributions, provide greater cost certainty and reduce the risk of unexpected or unaffordable bills.

²⁹ Mandala Partners (for Private Healthcare Australia), *Reducing Out-of-Pocket Costs for Australian Healthcare Consumers* (Report, 2025).

³⁰ Department of Health, Disability and Ageing, *Medical Cost Finder* (Web Resource, 2026); Mandala analysis for Bupa – July 2026.

³¹ Mandala Partners (for Private Healthcare Australia), *Reducing Out-of-Pocket Costs for Australian Healthcare Consumers* (Report, 2025).

Impact on patients and the health system

High out-of-pocket costs affect both patients and the broader health system. Patients may postpone consultations, delay treatment, ration follow-up appointments or forgo recommended care altogether. These impacts are greatest for people requiring repeated specialist care, including patients with chronic disease, complex conditions and ongoing mental health needs.

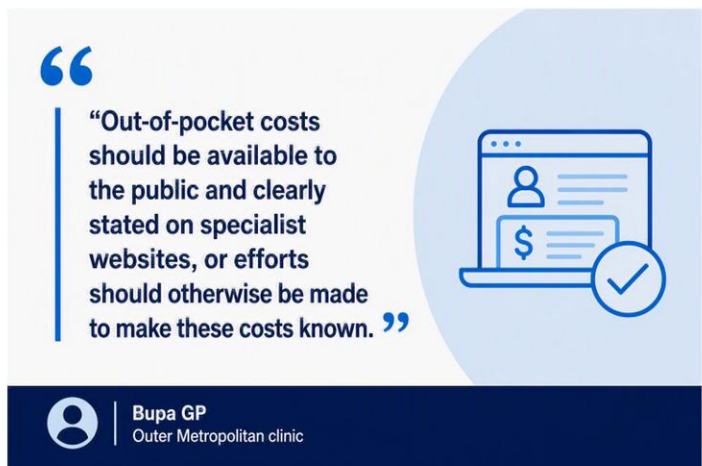
Affordability also influences how patients access care. Private hospitals deliver more than 40 per cent of Australian hospital admissions and approximately 70 per cent of elective surgery.³² Where high out-of-pocket costs deter private specialist consultations and treatment, patients may delay care or seek treatment through public outpatient clinics and public hospitals.³³ Improving affordability would therefore not only benefit individual patients but also support more effective utilisation of existing private specialist and hospital capacity, reducing pressure on public services.

These examples suggest that transparency reforms can support more informed decision-making, strengthen competitive pressure and reduce unwarranted fee variation without requiring governments to regulate individual provider prices directly. Taken together, improved affordability and transparency would support earlier access to care, more effective use of public and private capacity, stronger household financial resilience and better value from existing health expenditure.

Bupa's evidence and experience

1. Bupa practitioner survey

The June 2026 Bupa practitioner survey highlighted affordability as a significant barrier to specialist care. More than 80 per cent of surveyed GPs reported that high out-of-pocket costs often or very often delay or prevent patients from accessing specialist care. One GP noted that patients may be "prevented from accessing care altogether if they do not have the means to afford private care". Respondents reported that affordability barriers often result in patients remaining under general practice management for longer than clinically desirable. GPs also identified a lack of cost transparency as a major concern.



The specialist fees most associated with patient bill shock included:

- initial consultation fees
- follow-up consultation fees
- aesthetic or procedural fees
- multiple separate bills arising from a single episode of care.

³² Australian Government. (2024). Department of Health and Aged Care (Cth), [Private Hospital Sector Financial Health Check - Summary](#) (Report, 2024).

³³ B Keneally et al, [Delayed Recovery: Why Times Are Tough for Australia's Private Hospitals and What They Can Do About It](#) (Boston Consulting Group, 2024).

A similar picture emerged among nurses. More than 70 per cent identified out-of-pocket costs as a major barrier to specialist access, while more than 70 per cent reported that cost contributed to patient distress, delayed care or disengagement from treatment. Other respondents supported increased Medicare rebates, expanded bulk billing and capped gap arrangements as measures that could reduce financial barriers to specialist care.

“

“Patients should be able to see fees, Medicare rebates and exact out-of-pocket costs before booking, which would reduce uncertainty, prevent delays and improve affordability decisions. **”**



Bupa nurse
Metropolitan Clinic

“

“Private specialists are extremely expensive and for a lot of people, they are totally inaccessible and out of their budget. As our practice has a very high rate of pensioners, it makes it significantly more difficult for these patients to seek specialist care if their specialist does not offer a subsidised pensioner fee or bulk bill. **”**



Bupa Practice Manager
Metropolitan Clinic

Practice managers also reported significant affordability concerns. Two-thirds said specialist costs often or very often prevent patients from accessing care, while many described the additional administrative burden associated with helping patients navigate costs, identify affordable providers and manage ongoing care while specialist treatment is delayed. The survey findings suggest that rising specialist costs affect not only patients' ability to access care but also place additional pressure on primary care providers. Respondents consistently identified affordability and limited fee transparency as barriers to timely specialist treatment, particularly for lower-income patients, pensioners and those requiring ongoing specialist care. These findings reinforce the importance of reforms that improve cost transparency, informed financial consent and protection from unexpected out-of-pocket costs.

2. Bupa Medical Gap Scheme

Bupa is committed to reducing out-of-pocket costs through innovative models of care and targeted member initiatives. Our analysis of claims data indicates that our members generally experience lower median out-of-pocket costs than external benchmarks across several high-volume procedure groups. In 2025:

- Our Members First Ultimate dental program saved members more than \$18.8 million on over 439,000 general dental fillings.
- More than 277,000 members had a completely medical gap-free hospital admission, supported by around 1.5 million individual no-gap medical services delivered under Bupa's gap scheme.

Our experience demonstrates that insurer gap arrangements can make a meaningful contribution to reducing out-of-pocket costs. However, continued growth in member costs and substantial variation between regions indicate that affordability remains heavily dependent on specialist participation in voluntary agreement arrangements.

3. What we have heard from Bupa members

In preparing this submission, Bupa sought input from our customer voice and customer experience teams to ensure lived experience informed our response. To maintain customer privacy, these insights have been de-identified and paraphrased.

Across these experiences, a common theme was that affordability rather than clinical need often determined when customers accessed specialist care, with consequences for both their health outcomes and overall wellbeing. These frontline member stories bring to life the consequences of specialist affordability pressures for Australians accessing healthcare.

“Member felt the total cost wasn't transparent, and wasn't aware of additional fees, resulting in significant out-of-pocket expenses despite having private health insurance.”



Bupa member
Older cohort

“Member delayed getting a dental mouth guard to deal with a shoulder problem first, juggling necessary care within what the budget allows.”



Bupa member story
Younger cohort

“Member described the dread of the cascade: a GP visit that seems simple, then a scan, an MRI or X-ray, then a specialist, one thing following another, each with its own cost.”



Bupa member story
Younger cohort

“Member was surprised by a \$1500 bill for anaesthesia shortly before surgery.”



Private Health Insurance member
Older cohort

“Member discovered, well into the process for a straightforward procedure, that the gap would be \$3,300 including the anaesthetist. She had not thought to check no-gap providers and noted the lesson would not help her, as the surgery would not recur.”



Private Health Insurance member
Older cohort

4. Case study: Out-of-pocket costs and maternity care

High out-of-pocket costs are a key barrier for families considering private maternity care, even when they hold private hospital cover. Among people with private hospital insurance, 43 per cent identified high out-of-pocket medical expenses as a reason for not choosing a private hospital for childbirth, compared with 11 per cent who cited the cost of obtaining maternity coverage.³⁴

To help our customers with out-of-pocket costs, Bupa has partnered with Hatch Private Maternity in Brisbane to enable eligible members to receive a no-gap private maternity shared care experience. This means that eligible members had their antenatal and postnatal visits, pregnancy management fee and delivery fee covered by Bupa, saving our customers significant out-of-pocket fees. Partnerships

³⁴Private Healthcare Australia, [Maternity Care Coverage Submission](#) (Submission, January 2025) 2.

like this support providers engaging in innovative models of care by connecting members with these providers and provides better value for consumers with a no-gap hospital birth experience.

Recommendations Part 2: Improving affordability of specialist care

Recommendation	Actions
Strengthen consumer protections through a national no-surprise billing framework	Government should standardise informed financial consent requirements across Australia and require patients to receive clear estimates of reasonably foreseeable treatment costs before care is provided. New requirements should limit patient liability where disclosure requirements have not been met, subject to appropriate safeguards for emergency care.
Modernising referral arrangements	Government should modernise referrals so patients can readily choose another specialist when cost, availability or waiting times are barriers.
Ensure MBS rebates are adequately indexed	Government should index MBS rebates in line with appropriate inflationary indexes, such as the health inflation index.
Improve specialist fee transparency and patient choice	Government should expand the Medical Costs Finder to include specialist fees, Medicare benefits, insurer agreement participation, waiting times and expected out-of-pocket costs. New rules should require specialists providing privately funded services to publish indicative fees through nationally consistent reporting arrangements. The website should enable patients and referrers to compare specialists by location, specialty, fee range, waiting time and participation in insurer gap arrangements.
Improve access to publicly funded specialist services	Government should work with state jurisdictions to expand public outpatient specialist capacity in areas with the greatest unmet demand. There should be increased transparency of public outpatient waiting times and referral outcomes. Government should consider telehealth, outreach and other innovative models that improve access to publicly funded specialist care.
Strengthen oversight of specialist markets	Government should establish regular ACCC and Department reviews of specialist pricing, competition and billing practices. These reviews should monitor trends in out-of-pocket costs, fee variation and market concentration. Findings should be published to support transparency and inform future affordability reforms.

3. Innovative models to improve specialist access

Increasing specialist supply is essential, but workforce growth alone will not resolve current access and affordability pressures. Better-designed pathways can extend the reach of specialist expertise, support more care in primary and community settings, and preserve specialist appointments for patients with the greatest clinical need.

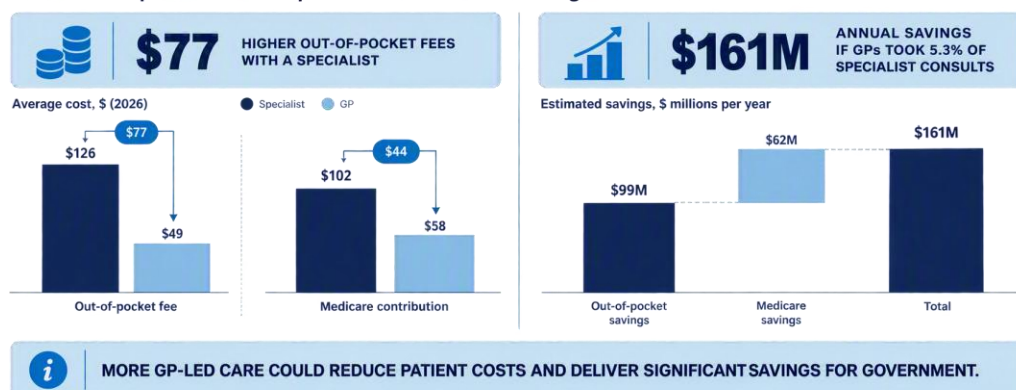
These approaches are not alternatives to specialist care but are mechanisms for ensuring that patients receive the most appropriate level of care at the right time while preserving specialist appointments for patients with the greatest clinical need. Collectively, they have the potential to improve affordability, reduce wait times, strengthen continuity of care and increase the effective capacity of Australia's existing specialist workforce.

Emerging model 1: Improving GP-specialist collaboration

One reform with significant potential for near-term implementation is improved collaboration between general practice and non-GP specialists. Patients with chronic and complex conditions may need specialist input for diagnosis, treatment planning and clinical escalation, but specialists do not need to manage every aspect of their ongoing care. Shared-care models can delineate responsibilities between GPs and specialists, allowing general practice to maintain preventive care, management of comorbidities, interim review and agreed monitoring while preserving access to specialist advice and unscheduled reassessment when required.³⁵

STRENGTHENING GP-LED CARE COULD IMPROVE SPECIALIST ACCESS AND REDUCE COSTS

Lower out-of-pocket costs for patients and lower costs for government.



A related innovation is structured secondary consultation, through which GPs can obtain patient-specific specialist advice without automatically making a referral for a face-to-face appointment. Australia currently has limited formal pathways for GPs to obtain this advice, and existing initiatives are not nationally consistent or sustainably available across all jurisdictions and specialties.³⁶ International evidence suggests that this is associated with improved access and avoidance of some specialist

³⁵ Royal Australian College of General Practitioners, [Shared Care Model between GP and Non-GP Specialists for Complex Chronic Conditions: Position Statement](#) (Position Statement, February 2023).

³⁶ Clinical Excellence Queensland, [eConsultant Implementation and Evaluation](#) (Web Page, 31 January 2022); Peter Breadon, [‘Secondary Consultations Would Improve Access to Specialists’](#) (Grattan Institute, 7 July 2025).

referrals.³⁷ Secondary consultation may also improve referral targeting by advising when direct specialist assessment is required.³⁸

MAINTAINING SPECIALIST OVERSIGHT THROUGH GP SPECIALIST SECONDARY CONSULTATIONS

A structured process that keeps specialists involved while improving access and efficiency.

GP specialist secondary consultation process



Case study: Queensland eConsult



Source: Consultmed (2025), Queensland eConsultant Service; Job et al, 'Implementing a General Practitioner-to-General Physician eConsult Service (eConsultant) in Australia' (2022); Queensland Government, *eConsultant Implementation and Evaluation* (2022); Mandala Partners analysis for Bupa – July 2026.

Queensland's eConsultant model demonstrates how this approach can operate in Australia. The service allows GPs to obtain patient-specific specialist advice electronically without automatically referring patients for a specialist appointment. The statewide service aims to respond within three business days. A program evaluation found that 86 per cent of participating patients avoided a face-to-face specialist visit.³⁹

Grattan Institute modelling estimates that a national secondary consultation system could avoid approximately 68,000 specialist referrals and save patients around \$4 million in out-of-pocket costs annually.⁴⁰ Although the reform would require additional government investment, some costs are offset through avoided specialist consultations resulting in improved access, better use of specialist capacity and lower costs for patients.⁴¹

Emerging model 2: Virtual specialist care and outreach networks

Telehealth has expanded rapidly over the past decade, but the most effective emerging models move beyond simple video consultations between a specialist and patient. Contemporary models integrate specialist telehealth, local primary-care providers and regional outreach into coordinated care pathways.⁴² Evidence from rural and remote Australian health services shows these models can improve access while reducing travel and associated costs. However, they require adequate MBS reimbursement for specialists to support these models and deliver the greatest benefit when embedded in local service delivery rather than operating as a standalone technology solution.⁴³

³⁷ Ken MM Peeters et al, 'Family Physician-to-Hospital Specialist Electronic Consultation and Access to Hospital Care: A Systematic Review' (2024) 7(1) *JAMA Network Open*

³⁸ Ken MM Peeters et al, 'Evaluation of an Interdisciplinary Electronic Consultation Service between General Practitioners and Medical Specialists in The Netherlands: A Prospective Cohort Study' (2024) 24 *BMC Health Services Research* 1438.

³⁹ Mater, *Mater Queensland eConsultant*; Clinical Excellence Queensland, *eConsultant Implementation and Evaluation* (31 January 2022).

⁴⁰ Peter Breadon et al, *Special Treatment: Improving Australians' Access to Specialist Care* (Grattan Institute, 2025).

⁴¹ Peter Breadon et al, *Special Treatment: Improving Australians' Access to Specialist Care* (Grattan Institute, 2025).

⁴² Bradford NK, Caffery LJ and Smith AC, 'Telehealth Services in Rural and Remote Australia: A Systematic Review of Models of Care and Factors Influencing Success and Sustainability' (2016) 16(4) *Rural and Remote Health* 3808.

⁴³ Bradford NK, Caffery LJ and Smith AC, 'Telehealth Services in Rural and Remote Australia: A Systematic Review of Models of Care and Factors Influencing Success and Sustainability' (2016) 16(4) *Rural and Remote Health* 3808.

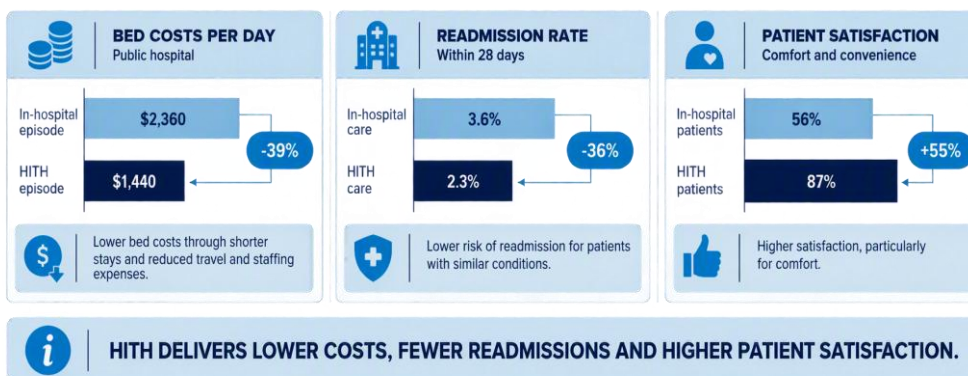
Similarly, outreach programs such as the Rural Health Outreach Fund demonstrate that bringing specialist expertise closer to rural communities can reduce geographic inequities while strengthening collaboration between local providers and metropolitan specialists.⁴⁴ National evaluation has found these models improve access, support continuity of care and can represent a cost-effective alternative to patient travel.⁴⁵

Emerging model 3: Hospital in the Home

Technological advances and improved remote monitoring capability have enabled increasing amounts of specialist-led care to be delivered outside traditional hospital settings. Hospital in the Home (HITH) and virtual ward programs allow patients requiring specialist oversight to receive treatment in their home or community while maintaining clinical governance through specialist, nursing and multidisciplinary teams.

HITH REDUCES HOSPITAL BED COSTS AND IMPROVES PATIENT OUTCOMES

Lower costs, fewer readmissions and higher patient satisfaction.



Source: Private Healthcare Australia (2023) *There's no place like home: reforming out-of-hospital care*; AMA (2023) *Out-of-hospital models of care in the private health system*. AIHW (2026) *Hospitals – Public hospitals and beds*; IHACPA (2023) *National Hospital Cost Data Collection – Public Sector Annual Report 2020-21*. Caplan et al. (2012) *A meta-analysis of "hospital in the home"*; Edgar et al. (2024) *Admission avoidance hospital at home*. Montalto et al. (2020) *Home ward bound: features of hospital in the home use by major Australian hospitals, 2011-2017*. Levine et al. (2019) *Hospital-Level Care at Home for Acutely Ill Adults*; Lustman et al. (2025) *Lessons from a large national "hospital at home" program*. 6. Leff et al. (2006) *Satisfaction with hospital at home care*; Mandala analysis 2026

While HITH is not a direct substitute for specialist assessment, it can improve access by increasing effective specialist capacity, supporting earlier discharge, avoiding unnecessary admissions and allowing specialists to manage a greater number of patients across hospital and community settings. Shifting appropriate care out of hospital could generate significant health-system efficiencies while maintaining patient safety and high levels of patient satisfaction.

Analysis by Mandala Partners demonstrates that private system alone could redirect approximately 23,000 hospital bed days and save \$24 million in costs if HITH were expanded for just ten diagnosis groups.⁴⁶ For rural patients, these models can also reduce travel requirements and enable specialist-supported care closer to home.

⁴⁴ Department of Health and Aged Care (Cth), [Evaluation of Outreach Programs: Report Volume 1](#) (Report, 2023).

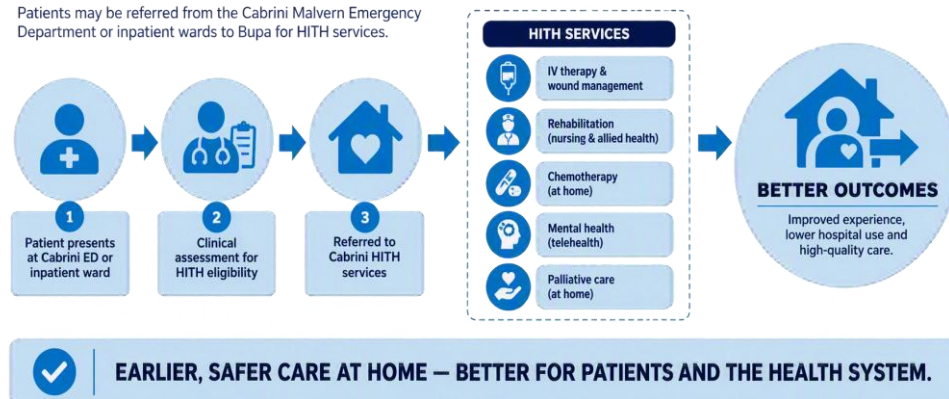
⁴⁵ Department of Health and Aged Care (Cth), [Evaluation of Outreach Programs: Report Volume 1](#) (Report, 2023).

⁴⁶ Analysis by Mandala Partners for Bupa – July 2026. Analysis demonstrated that Increased HITH uptake across the top 10 DRGs could free up significant in-hospital bed days and reduce costs for patients and the system. This estimate is conservative as it captures only a small subset of over 700 DRGs, and there is high potential to expand HITH beyond these admission types (e.g. knee replacements, diabetes, stroke recovery, coronary artery disease and heart failure, and many others).

BUPA AND CABRINI HITH PARTNERSHIP

Enabling Acute Substitutional HITH services for eligible patients.

Patients may be referred from the Cabrini Malvern Emergency Department or inpatient wards to Bupa for HITH services.



Emerging model 4: Modernising referral pathways

Australia should establish nationally consistent digital referral pathways connecting general practice, public outpatient clinics and private specialists. Referrals are managed through multiple disconnected channels, creating variation in referral quality, information exchange and patient experience. Bupa's 2026 practitioner survey highlighted this problem with 100 per cent of respondents indicating that current referral pathways lead to delayed or missing correspondence.

The Australian Government's 2026 consultation identified digital capability and standardised referral requirements as possible areas for reform.⁴⁷ Digital pathways should provide more than electronic documents. They should enable structured and secure referrals, clinical triage, acknowledgment and status updates. Referrers should be able to confirm receipt and respond to requests for further information, while patients should receive confirmation and clear information about next steps.

National requirements should build on existing standards. Victoria's eReferral standard specifies minimum requirements for the secure and interoperable transfer of structured referral information.⁴⁸ The Australian Digital Health Agency identifies common standards as essential to ensuring clinical information can move between systems and support informed decision-making.⁴⁹ Digital pathways should also support Requests for Advice and secondary consultations where a GP needs specialist guidance but the patient may not require an appointment. Where direct assessment is necessary, structured information should support appropriate triage and prioritisation.⁵⁰ A nationally interoperable system would improve referral quality, transparency and coordination while reducing manual administration and the risk of lost or delayed referrals.

⁴⁷ Australian Government Department of Health, Disability and Ageing, [Consultation Paper: Modernising Referral Pathways](#) (11 February 2026).

⁴⁸ Victorian Department of Health, [eReferral Standard](#) (updated 17 November 2022).

⁴⁹ Australian Digital Health Agency, [Interoperability](#) (updated 20 July 2026).

⁵⁰ Australian Government Department of Health, Disability and Ageing, [Consultation Paper: Modernising Referral Pathways](#) (11 February 2026); Victorian Department of Health, [eReferral Standard](#) (updated 17 November 2022).

Recommendations Part 3: Innovative models to improve specialist access

Recommendation	Actions
National GP-specialist consultation service	Government should establish a nationally funded GP-specialist secondary consultation service and expand shared care pathways so GPs can access public and private specialist advice without requiring a face-to-face referral in every case, allowing specialist capacity to be focused on patients with the greatest clinical need
Expand integrated virtual specialist care and outreach networks	Government should expand integrated virtual specialist care, telehealth and outreach networks, particularly in regional, rural and remote communities, so patients can access specialist expertise closer to home and move seamlessly between virtual and in-person care when required.
Progress HITH and virtual ward programs	Government should progress and scale Hospital in the Home reform and virtual ward programs to deliver appropriate specialist led care outside traditional hospital settings, reducing avoidable admissions, supporting earlier discharge and increasing effective specialist capacity.
National interoperable digital referrals	Government should establish nationally interoperable digital referral pathways that support electronic referrals, clinical triage, Requests for Advice, referral tracking and information sharing between primary care, specialists and hospitals, improving care coordination and reducing delays.

4. Conclusion

Access to specialist care is becoming more difficult for many Australians due to workforce shortages, long waiting times, rising out-of-pocket costs and fragmented referral pathways. While increasing specialist supply remains important, workforce growth alone will not address the underlying access and affordability challenges facing patients.

Bupa encourages the Committee to prioritise three reforms that would deliver the greatest impact:

1. **Establish a coordinated national specialist workforce planning and training system** to address workforce shortages and improve regional access.
2. **Improve transparency and affordability for patients** through stronger informed financial consent, greater visibility of specialist fees and waiting times, and protections against unexpected costs.
3. **Scale nationally consistent GP-specialist consultation and referral pathways** to ensure specialist expertise is used more effectively, and patients receive timely care at the most appropriate level.

Together, these reforms would improve patient choice, reduce delays, make better use of existing specialist capacity and strengthen the sustainability of Australia's mixed public and private health system.