Executive Summary

Fee Transparency in Health Care: Informed Financial Consent and Split Billing Practices

Under Medicare, individuals have the freedom to choose their own private health care providers, while practitioners retain the ability to determine the price of their services. However, for such a system to function effectively and equitably, it is essential that patients understand the fees they may be charged before they receive care. Fee transparency is essential for informed decision-making and trust in the system.

1. Purpose

The Department has drafted a detailed public consultation paper on Fee Transparency in Health Care. The paper outlines how fee transparency empowers patients, supports choice, and promotes trust in the health system. It highlights the importance of clear communication regarding health care costs, identifies challenges in current practices, and seeks stakeholder input on strengthening Informed Financial Consent (IFC) and addressing problematic split billing. This executive summary provides a concise overview of the issues outlined in that paper.

IFC is one part of potential reforms under consideration to improve affordability, transparency and access to specialist medical care. Alongside work to strengthen IFC, other reforms under consideration include modernising referral pathways, changes to professional scope of practice and options for addressing excessive fees. Taken together, these reforms recognise that improving affordability and outcomes for patients requires coordinated reform across the patient journey.

2. What is Informed Financial Consent?

Informed Financial Consent (IFC) is an ethical and professional standard requiring patients to be aware, **understand and agree** to the expected costs of their health care **before** receiving treatment. There is strong support for the principle of IFC across Australian health professions.

IFC does not require practitioners to guarantee the final costs or predict rare or unforeseen complications, rather it is a best estimate using the practitioner's best knowledge of the price of care.

Professional codes and guidance issued by bodies such as the Medical Board of Australia (MBA) and the Australian Medical Association (AMA) emphasise that discussing fees and likely out-of-pocket costs with patients prior to treatment is an important element of good medical practice and supports patient autonomy and shared decision-making. But while widely recognised, limited regulatory oversight and remedies for patients raises questions about its effectiveness in protecting patients from unexpected financial impacts.

Recent consumer research reinforces these findings. A February 2026 report commissioned by Private Healthcare Australia, found that many consumers are unaware of the full costs of medical care upfront. The report found that 44% of consumers were unaware of specialist fees prior to their appointment. For both hospital and specialist fees, the research found that:

- 36% lacked sufficient clarity to plan for treatment expenses
- 55% of consumers reported receiving bills that were unexpectedly large

- 38% of consumers received bills they did not anticipate.

Consumers reported experiencing surprise or late invoices, upfront deposits, and complex or fragmented billing arrangements, all of which reduce patients' ability to plan and make informed choices. These experiences were associated with embarrassment in discussing fees, loss of agency over health care decisions, and deferral of care.

IFC is not currently embedded as a clear, enforceable patient right, instead obligations are fragmented across professional standards, guidance material and general consumer law, with limited enforceability and inconsistent remedies for consumers.

3. Challenges in obtaining Informed Financial Consent

1. **Complexity of services:** For some treatments, patients may have multiple providers and billing arrangements make it difficult for patients to understand total costs. This fragmentation means patients may receive separate bills from each provider, often with little coordination or explanation.
2. **Timing of consent:** IFC is often provided late, limiting true informed choice. Late disclosure can lead to patients feeling pressured to agree to treatment without fully understanding the costs involved.
3. **Information gaps:** Patients may not receive comprehensive details about all fees, including ancillary charges. Sometimes, only the main procedure costs are discussed, leaving patients unaware of additional expenses such as pathology, imaging, or follow-up care.
4. **Provider variability:** There is variability to the approach across providers and medical specialties. Some practitioners offer detailed fee breakdowns, while others provide minimal information, leading to uneven patient experiences.
5. **Language and literacy barriers:** Patients with limited English or health literacy may struggle to comprehend cost information. Complex medical and financial terminology may not be accessible to all, increasing the risk of misunderstanding.
6. **Emergency care:** IFC may not be feasible in urgent or emergency settings, increasing risk of unexpected bills.
7. **Insurance complexity:** Understanding the interaction between Medicare, private health insurance, and out-of-pocket costs is challenging. Patients may find it difficult to predict what will be covered and what they must pay themselves, especially when policies have exclusions or changing benefits.
8. **Regulatory oversight:** Lack of clear and effective regulation and enforcement pathways leads to gaps in protection and transparency.

4. How IFC is regulated now

4.1 Laws and rules

IFC appears across multiple legal and regulatory frameworks in the health system; however, it is not established as a clear, enforceable patient right. Instead, IFC obligations are fragmented, inconsistently defined, and primarily oriented towards professional standards or system level compliance, rather than individual patient protection.

Under the Private Health Insurance (Health Insurance Business) Rule 2018, Part2A 7C requires that to be included in the second-tier eligible hospitals class, a hospital must make provisions for

Informed Financial Consent. Regulator guidance also confirms that other hospitals and health service organisations must also provide Informed Financial Consent. The framework is designed for system level regulation, including some individual patient protections that are included in the assessment criteria.

The Dental Benefits Rules mandate IFC before services under the Child Dental Benefits Scheme are provided, requiring providers to inform patients about likely benefits and out-of-pocket costs and obtain consent. Still, IFC is undefined, and there are no remedies for patients if consent is not properly obtained, linking compliance to benefit eligibility rather than patient rights.

4.2 Professional codes

Many health professional bodies set ethical standards for IFC in published codes, encouraging practitioners to provide clear information about fees. Compliance with these codes may be voluntary, or enforced through professional conduct/notification procedures, which rely on patient complaints/notifications.

While codes promote transparency, their impact is limited without robust regulatory backing, and specific patient remedies.

Across all medical colleges, IFC is recognised as an ethical expectation; however, the specificity, scope and strength of obligations vary significantly. Key differences include:

- Level of detail: from highly prescriptive requirements to broad, principle-based statements.
- Format expectations: some codes emphasise written IFC, while others accept verbal discussion.
- Timing: varying requirements about when IFC must be provided.
- Patient centred focus: differing emphasis on comprehension, alternatives and financial implications.
- Definitions: only some codes explicitly define IFC as a dialogue, a written disclosure, or a formal process.

The table below summarises key professional codes applying to medical practitioners and their IFC requirements. For a more detailed overview of existing codes, please refer to Table 1.5 in the consultation paper.

Body	IFC Requirements
Medical Board of Australia	Good Medical Practice: Code of Conduct obliges doctors to inform patients of fees and charges in a timely way so they can decide whether to proceed (no prescribed format or detail). If a breach of this requirement varies significantly from the standard of medical practice expected, a doctor's registration to practice may be affected, but there are no patient-specific remedies.
Australian Medical Association	Advises IFC as an ethical dialogue covering fees, Medicare/private health insurance benefits and likely out-of-pocket costs (encourages written estimates/templates, but not mandatory).
Royal Australasian College of Surgeons	Professional expectation to obtain IFC before treatment and disclose surgeon fees and potential costs of subsequent/revisional surgery (written/signed IFC recommended where practicable).
Australian Society of Anaesthetists	Defines IFC as a verbal or written dialogue; "gold standard" is a written fee estimate/range and likely out-of-pocket costs provided before the day of procedure with patient acceptance.

Body	IFC Requirements
Australian College of Dermatology	Requires fees to be available and discussed if requested (no proactive IFC requirement and no requirement to disclose rebates or out-of-pocket costs).
Royal Australian and New Zealand College of Psychiatrists	Treats costs as part of broader informed consent for treatment/reports, without defining or prescribing a separate (or written) IFC process.
Royal Australian and New Zealand College of Radiologists	Requires patients be given clear information on likely fees and rebates prior to treatment; where out-of-pocket expenses are anticipated, provide written cost information and seek a signed acknowledgement (and notify changes in writing).
Council of Presidents of Medical Colleges (CPMC) Framework	Provides a principles based IFC framework requiring patients be given clear, written information about expected medical fees, Medicare and private health insurance rebates, and likely out-of-pocket costs before treatment. Emphasises patient understanding, timing before commitment to treatment, and documentation of consent.

5. Current IFC complaint pathways

Australia's IFC complaints and regulatory pathways are spread across several bodies, each with unique responsibilities and powers. None are specifically designed for IFC issues, so patients often face a complex system with few straightforward remedies. Key avenues include the Medical Board of Australia (MBA)/Australian Health Practitioner Regulation Authority (Ahpra), the Professional Services Review (PSR), state health complaints commissions, the Private Health Insurance Ombudsman, and hospital feedback channels, each addressing different aspects of health care delivery and billing.

1. **Medical Board of Australia (supported by Ahpra)** regulate medical practitioner conduct under the National Law, focusing on public safety and professional standards. While anyone can lodge a notification, action is taken only where matters meet regulatory thresholds. Given the Board's notification load and legislative framework, it prioritises consideration of matters relating to public safety. Its current capacity to take a more active role in reviewing IFC compliance is limited. Outcomes of Board reviews are disciplinary in nature (e.g. conditions, suspension), not remedial, and there is no mediation or compensation for patients.
2. **Professional Services Review (PSR)** operates under the *Health Insurance Act 1973* and focuses on Medicare and pharmaceutical benefits compliance and the protection of Commonwealth expenditure. In the context of Medicare, the PSR assesses whether a practitioner engages in inappropriate practice. This is defined in the Act as conduct in connection with rendering or initiating Medicare services if the conduct would be unacceptable to the general body of the practitioner's clinical peers. Sanctions available to the PSR include reprimands, counselling, partial or full disqualification from claiming certain Medicare benefits, and repayment of Medicare benefits to the Commonwealth. The PSR does not address individual complaints or disputes, and does not provide compensation or redress to patients.
3. **State Health Complaints Commissions** can consider complaints about public and private health care providers, including failures in IFC and unexpected charges. Powers, definitions and reporting vary significantly across jurisdictions, and outcomes generally focus on service improvement or referral rather than compensation.

4. **Private Health Insurance Ombudsman** handles disputes regarding out-of-pocket costs and insurance arrangements, focusing on transparency and fairness in billing. While IFC is recorded as a complaint category and the PHIO may facilitate discussions between parties, it does not have the capacity to enforce IFC or provide remedies where IFC has not been obtained.
5. **Hospital and health service feedback mechanisms** allow patients to raise concerns with hospitals or health services, prompting internal reviews and potential improvements.

Overall, IFC lacks a clear legal foundation and patients must navigate fragmented, overlapping systems, rarely with a single entry point or meaningful remedy for financial harm.

6. Split billing

Split billing involves separating elements of a single episode of care across different billing arrangements. Typically, part of the cost is billed through Medicare or private insurance, while additional fees, such as administration, booking, or room charges are billed directly to the patient. Often private health insurers and the Government have no visibility of these fees.

This practice can result in incorrectly claiming bulk billed incentives, bypassing no gap or known gap arrangements, and increase in out-of-pocket expenses for patients. Patients often lack visibility of the full cost structure, undermining trust and informed decision-making.

These structural features can reduce transparency and blur accountability for patients. Regulatory oversight of split billing is limited, with inconsistent enforcement and unclear guidance. The complexity of billing arrangements and terminology further complicates transparency, making it difficult for patients to identify and challenge inappropriate charges.

Consideration could be given to how regulation, professional standards and patient education might better align to support clarity and fairness in health care fees in the context of split billing.

7. Options for reform

The options outlined in the table below present some potential approaches to reforming IFC. These options could be considered either as stand-alone measures or in combination. No decisions have been made by Government on a preferred approach. The options are presented to support discussion and generate feedback on the relative merits, risks and implementation considerations of different reform pathways, including the appropriate role of legislation, regulation, compliance and education in strengthening IFC.

Implementation feasibility is a significant consideration across the options presented below. It is noted that each option requires additional exploration of the practical considerations to successfully implement reform.

Option	Description
Expand the function of the Professional Services Review	Amend the *Health Insurance Act 1973* and broaden the PSR Scheme so PSR can review practitioners who fail to obtain IFC before treatment. This would rely on existing Medicare compliance infrastructure and could result in orders to refund MBS fees or penalties for repeat offenders. While it creates clear legislative obligations and leverages current systems, enforcement may focus on Medicare access rather than direct patient remedies and may increase compliance burdens.
Expand the role of the Department of Health, Disability and Ageing compliance mechanisms	Amend the *Health Insurance Act 1973* to clarify IFC obligations, and use departmental audits, tip-off lines, and compliance actions to monitor adherence. This would make IFC a compliance issue for the Department and enable targeted enforcement, but may still deliver only indirect sanctions focused on providers, not patient compensation, and requires additional funding and legislative changes.
Expand the role of Ahpra and the Medical Board of Australia to regulate IFC under the National Law Use the National Law to enforce IFC through health practitioner regulation via Ahpra and/or health complaints agencies	Strengthen IFC obligations under the Health Practitioner Regulation National Law, allowing Ahpra and health complaints entities to enforce compliance. This approach uses existing regulatory bodies and creates consistent frameworks, but actions focus on practitioner discipline rather than consumer redress. This National Law requires the agreement of all States and Territories to amend.
Establish a new regulator or regulatory function for an existing regulator (such as a consumer rights/fair trading regulator) to investigate IFC complaints	Create a statutory authority with powers to investigate and resolve IFC complaints, focusing solely on IFC obligations and offering patient-centred remedies. This option could also provide a front door for consumers to make a complaint, with the investigation and enforcement being referred to another appropriate body. While this provides a clear, consumer-focused pathway and national consistency, it requires substantial legislative work, ongoing resources, and risks duplication with existing bodies if roles are not well defined.
Education, guidance and voluntary compliance (no legal change)	Promote IFC through education, professional guidance, training, and voluntary tools such as the Medical Costs Finder. This option is low-cost and avoids legal risks, but lacks enforceability and accountability and may not achieve consistent uptake or solve hidden fee issues.

8. Questions for consultation

You are invited to provide any general views and comments on how you consider Informed Financial Consent and disclosure arrangements should be reformed.

We invite you to provide your views on fee transparency in health care by completing our online survey on Consultation Hub and to submit any additional written comments via email to specialistaffordability@health.gov.au with the subject line "Fee Transparency". A copy of the questions included in the survey are below. Submissions close on Wednesday 5 August 2026. Thank you for your interest in this important matter.

Informed Financial Consent

1. Which of the following best describes you? (Select one)
    a. Medical practitioner/specialist
    b. Junior doctor / doctor in training
    c. Allied health professional
    d. Nurse or midwife
    e. Health service administrator / manager
    f. Consumer or member of the community
    g. Consumer advocate / representative organisation
    h. Regulator or government agency representative
    i. Other (please specify)
2. If you are a medical practitioner, what is your primary area of practice?
    a. Surgical specialty
    b. Medical specialty
    c. Diagnostics (e.g. radiology, pathology)
    d. General practice
    e. Other
3. Which setting do you primarily work in or interact with? (Select all that apply)
    a. Public healthcare
    b. Private healthcare
    c. Both public and private
    d. Not applicable
4. Which state or territory are you based in?
    a. NSW
    b. VIC
    c. QLD
    d. WA

e. SA

f. TAS

g. ACT

h. NT

i. Not Australia based

5. Do you think IFC should be legally enforceable in Australia? Yes/no/unsure.

6. Do you think medical providers should be penalised for not providing IFC to their patients? Yes/no/unsure.

7. Which regulatory approach do you consider most effective for strengthening IFC? Please rank the options below from 1 (most preferred) to 6 (least preferred).

    a. Expand function of Professional Services Review

    b. Expand the role of the Department of Health, Disability and Ageing compliance mechanisms

    c. Ahpra and/or health complaints agency enforcement of IFC using National Law Provisions

    d. Establish a new regulator to investigate IFC complaints

    e. Expand existing regulators such as the Australian Competition and Consumer Commission (ACCC) to enforce IFC obligations

    f. Education, guidance and voluntary compliance (no legal change)

8. Should IFC require disclosure of the total expected cost of an episode of care, including costs billed separately by other providers (e.g. anaesthetists, pathology, devices)?

    a. Yes, in all cases

    b. Yes, for higher cost or planned care only

    c. No, IFC should remain limited to individual provider fees

    d. Unsure

9. Who should IFC obligations apply to? (Select all that apply)

    a. All registered health practitioner

    b. Medical practitioners only

    c. Medical practitioners in the private setting

    d. Specific specialties or types of care

    e. Only high cost or discretionary services

10. Which information should IFC reasonably require providers to disclose? (Select all that apply)

    a. Expected fees charged by the provider

    b. Likely out of pocket costs

    c. Costs billed by other practitioners

d. Range of possible costs and uncertainties
e. Treatment alternatives and cost implications
f. Timing and format of disclosure
g. Relevant Medicare Benefit item number/rebate
h. Private health insurance benefits
i. Other

11. Should IFC be provided in writing? *(Select all that apply)*
    a. Yes always
    b. Only above a certain monetary threshold
    c. Only if requested by the patient
    d. No, verbal discussion sufficient
    e. At the discretion of the provider
    f. Yes, but with exceptions (please specify)
12. Do you think existing professional codes of conduct provide sufficient clarity on IFC? Yes/no/unsure
13. What supports would be most important to enable stronger IFC requirements? *(Circle all that apply)*
    a. Clearer guidance for providers regarding their obligations, including standard templates
    b. Clearer guidance for patients in how to participate in discussions about the cost of their care
    c. Guidance to support culturally safe dialogues between patients and providers
    d. Digital systems to support cost disclosure
    e. Other, please specify:
14. Are there key risks or unintended consequences that IFC reforms should seek to avoid?
15. What role could digital tools play in supporting IFC?

Split billing

16. Should providers be required to issue a single bill for all items/services associated with an episode of care? Yes/no/unsure
17. Are there any system level incentives or changes in regulation that would support providers to issue a single bill?

Miscellaneous

18. Are there any key issues or considerations missing from this paper?
19. Do you have any additional comments on IFC or options for reform?