Consultation Paper

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

1. Purpose

Outside of the public health system, individuals have the freedom to choose their own health care providers, while practitioners retain the ability to determine the price of their services. For this system to function effectively and equitably, it is essential that patients understand the fees they may be charged before they receive care.

Patients making decisions about their care, or the care of a loved one, can be incredibly vulnerable. There is often strong information asymmetry in the interactions between a patient and their health care provider/s. They are reliant on their health care provider to help them identify a course of treatment and their alternatives about how that treatment could be accessed through the health system. Patients often have limited awareness of the costs of a course of treatment prior to commencing their journey. This can be especially challenging when there are multiple providers involved in a course of treatment, each with different levels of Medicare and private insurance coverage. Some patients may feel ill equipped or uncomfortable about asking for information about costs. Where they do have that information, lack suitable benchmarks to assess whether the fee that they have been charged is reasonable and appropriate. It's essential therefore for patients to have clear information on costs to make informed decisions about their care.

This paper explores the practical challenges associated with current Informed Financial Consent (IFC) and split billing practices, including issues of transparency, compliance and regulatory visibility. It also seeks to identify additional concerns that may not yet be fully understood. The paper outlines key questions and invites stakeholder feedback to inform the development of proportionate, practical and effective options to improve IFC and address problematic split billing practices.

For the purposes of this paper:

- **Informed Financial Consent (IFC)** means that before treatment, a patient is given clear, understandable information about what their care is likely to cost, so they can make an informed decision about whether to proceed. It is commonly understood as an ethical and professional standard requiring the provision of clear information about the expected costs of health care to patients prior to treatment. It does not require practitioners to guarantee the final costs or predict rare or unforeseen complications, but it provides patients with a best estimate using the practitioner's knowledge of the price of care. While widely recognised, there is limited regulatory oversight and remedies for patients, which raises questions about its effectiveness in protecting patients from unexpected financial impacts. This discussion paper analyses features of IFC and considers IFC practices within the Australian health care context.

- **Split billing** refers to practices where a provider separately bills for the same episode of care in a way that limits transparency about the full cost of services. For example, where part of the cost of care is billed through Medicare or private health insurance, while additional charges, often described as *administration or booking fees*, are billed separately to the patient. It could also include splitting MBS services over multiple days to circumvent the multiple services rule or equivalent. Split billing may result in incorrectly claimed bulk billing incentives, circumvent no gap or known gap arrangements with private health insurers, or increase patients' out-of-pocket costs.

While potential approaches to reform are identified for discussion, the purpose of this paper is to seek views on whether and how IFC and split billing regulation should be strengthened, including the role of guidance and enforcement.

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. Scope

In scope

- *Current medical context*: how IFC is applied in health care settings, including public and private sectors, allied health and across hospital and outpatient care.
- *Patient experience and provider practices*: challenges faced by patients, clinicians and practices in understanding, delivering and receiving IFC, including issues of timing, clarity and documentation.
- *Identification of gaps*: areas where IFC may not be operating effectively, where expectations are unclear, or where existing arrangements do not adequately support transparency or informed decision making.
- *Split billing practices*: consideration of how split billing operates in practice, its interaction with IFC, and the potential impacts on patients, insurers and government payers.
- *Regulatory and compliance landscape*: relevant legislation, standards, guidance and oversight mechanisms that currently affect IFC and related billing practices.
- *Options for improvement*: consideration of possible approaches to strengthen IFC and address problematic split billing practices, including the role of guidance, regulation, oversight and enforcement.

Out of scope

- *Detailed cost modelling or pricing analysis*: this paper does not attempt to calculate, benchmark or compare medical fees, rebate charges, or explore price regulation.
- *Broader health system reforms*: issues unrelated to IFC and billing transparency, such as workforce planning or service availability are excluded.

- *Individual compliance or enforcement matters*: this paper does not consider or assess the conduct of individual practitioners, practices or hospitals.
- *Non-medical health services*: aged care, disability services and other non-MBS medical settings are outside the scope of this paper.

3. What is Informed Financial Consent (IFC)?

IFC is the process of making sure a patient is aware, **understands and agrees** to the expected costs of their health care, ideally **before** receiving treatment. It means the clinician or provider clearly explains:

- what the service or procedure will cost
- any out-of-pocket fees the patient may need to pay
- what rebates or insurance coverage might apply
- whether there are lower cost alternatives

The patient is then able to ask questions, consider their options and provide voluntary agreement based on the most accurate information available. IFC supports transparency, protects patients from unexpected bills, and helps them make informed decisions about their care.

There is strong support for the principle of IFC across the Australian medical profession. Professional codes and guidance materials 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.

This professional commitment has been further reinforced through the Medical Specialist Professionalism Framework Ethical Billing and Fee Transparency,[1] developed by the Council of Presidents of Medical Colleges (CPMC), which articulates shared expectations for ethical billing, fee transparency and the timely provision of IFC across medical specialties. The Framework consolidates existing professional standards and provides clearer guidance to specialists on communicating fees and potential out-of-pocket costs, representing a positive, sector led step to support IFC in practice.

Most medical practitioners seek to do the right thing and are committed to providing their patients with information about costs before care is delivered. However, despite this strong professional endorsement of IFC, evidence suggests that patient awareness and understanding of costs prior to treatment is not always achieved. Consumer research indicates that a significant proportion of patients are not informed of specialist fees in advance, and many report experiencing unexpected or higher than anticipated charges after treatment (‘bill shock’), highlighting a gap between professional intent and patient experience. This suggests that while the concept of IFC is widely supported, current arrangements do not consistently deliver the level of fee transparency that IFC is intended to provide.

[1] Council of Presidents of Medical Colleges (CPMC). *Ethical Billing and Fee Transparency: A Medical Specialist Professionalism Framework*. 2026.

Patient experience data for 2024–25 indicates that medical specialist services are widely used, with over two in five people (40.4%) seeing a specialist in the past year, rising to almost two-thirds among people aged 85 years and over. Despite this high reliance, nearly one in five people (18.3%) delayed or did not see a medical specialist when needed, with cost cited as a reason by 8.6% of respondents. Cost-related delay was particularly pronounced among younger adults, women, people with long-term health conditions, and those living in socio-economically disadvantaged areas. These findings suggest that specialist care is essential and that high costs and uncertainty about costs can act as a barrier to timely care. Strengthening IFC requirements, including clearer upfront disclosure of total expected costs, may support more informed decision-making for patients who rely heavily on specialist services.[2]

Recent consumer research reinforces these findings. A February 2026 report commissioned by Private Healthcare Australia,[3] found that many consumers are unaware of the full costs of medical care upfront and that "bill shock" is common. 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% reported receiving bills that were unexpectedly large
- 38% received bills they did not anticipate

Consumers reported experiencing surprise or late invoices, upfront deposits, and complex or fragmented billing arrangements, all of which reduced their 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.

Similar findings are reflected in a 2024 Commonwealth Bank report on health spending,[4] which found in the past 12 months, 27% of consumers had experienced bill shock (16% when seeing a non-GP medical specialist and 11% when seeing a GP), and 45% reported they do not usually ask about costs when seeing a GP or non-GP medical specialist, they just pay the bill after the appointment.

The Consumers Health Forum of Australia (CHF) has emphasised the importance of accurate and accessible cost information for consumers to make informed choices about their health. Cost concerns are a major cause of care-seeking decisions, with 41.4% of respondents reporting that cost is very or extremely influential in whether they seek care.[5] CHF highlights that one challenge is that there's no clear definition of IFC and there are differences between consumer and provider understanding of what constitutes genuine IFC. Most respondents want clear, upfront information about health care costs to help them plan expenses.

[2] Australian Bureau of Statistics (ABS) (n.d.) *Patient experiences*, available at: www.abs.gov.au/statistics/health/health-services/patient-experiences/latest-release#data-downloads (Accessed 27 February 2026).
[3] Mandala Partners, *Restoring Affordable Access to Specialist Care in Australia* (2023).
[4] Commonwealth Bank of Australia. *Broker Patient Insight Report*. CommBank Health, 2024.
[5] Consumers Health Forum of Australia (2026). Health consumers' experiences and perceptions of healthcare costs. Canberra, Australia

These findings indicate that current arrangements do not reliably prevent surprise billing or ensure meaningful financial transparency. Developing a more structured, consistent approach to IFC offers one avenue to address these issues. While IFC cannot guarantee affordability or satisfaction with pricing, it has the potential to reduce bill shock, improve patient agency, and support more informed and equitable health care decision making.

4. Challenges in obtaining Informed Financial Consent

This section addresses key challenges faced by health care providers in giving patients the information they need to make informed decisions about their care.

4.1 Understanding consent

Consent is a foundational principle in health care, serving both legal and ethical functions. It reflects the principle that patients retain ultimate authority over decisions regarding their care and must be provided with sufficient information to make those decisions freely and meaningfully.

IFC builds on this concept by extending consent beyond clinical factors to include financial aspects of care. However, the utility of IFC is highly dependent on how it is defined, who it applies to, and whether it can be enforced. In practice, IFC is not a single, consistent concept. It may be understood as:

- verbal disclosure of expected costs prior to treatment;
- a written acknowledgement of fees for a specific procedure; or
- a more collaborative, two-way process resembling shared decision making, in which patients communicate financial preferences and constraints before consenting to care.

This variability contributes to the inconsistent application of IFC across the health system and creates uncertainty for both patients and providers about what constitutes adequate financial consent. Further, within the current regulatory landscape, consumer protections relating to IFC remain limited. While professional bodies such as the Australian Medical Association (AMA) recommend IFC as good ethical and professional practice, adherence to these expectations are mostly voluntary. Patient's may have difficulty obtaining a remedy where financial consent is inadequate or absent as there are limited accessible and affordable recourse options. As a result, adherence to IFC practices varies significantly.

4.2 Unpredictability of care and costs

A key challenge in implementing IFC is the inherent unpredictability of health care. Providers may be able to estimate fees for planned services but clinical complexity, complications, or changes in treatment plans can result in higher than anticipated costs.

Any IFC framework must balance the provision of accurate cost information with sufficient flexibility to adjust costs due to clinical circumstances. Without clear parameters, there is a risk that IFC becomes overly rigid and impractical and provides limited value to patients. Managing cost variability, including how and when patients should be informed of changes to expected fees, remains a central challenge.

4.3 Timing of financial consent

The timing of IFC is critical to its effectiveness. For consent to be meaningful, patients must receive financial information early enough to consider alternatives, seek clarification, or decide not to proceed. However, there is no single requirement of how far in advance IFC should occur.

In some cases, cost discussions occur very close to the time of treatment, when patients may feel pressured or have limited practical ability to change course. In other circumstances, such as emergencies or urgent care, obtaining prior financial consent may not be possible or appropriate. These realities highlight the need for a proportionate approach to timing that recognises both patient autonomy and clinical urgency.

4.4 Multiple providers involved in a health care service

Most consumers reasonably perceive a surgical procedure as a single service. In practice, however, private health care is delivered through a multi-provider model involving several independent businesses, such as the surgeon, assistant surgeon, anaesthetist, pathologists, diagnostic imaging providers, and the hospital itself. Each operates independently and may have separate billing and fee structures.

This can create significant challenges for patients. No single provider is required to inform consumers of the total cost of care, making it difficult for patients to understand or anticipate the full financial impact of treatment. As a result, consumers can often be exposed to unexpected out-of-pocket costs, surprise bills, and significant frustration.

Generally, each provider involved in a procedure issues their own invoice, leaving patients to navigate and coordinate payment for what may be several separate charges arising from what they experienced as a single episode of care. Changes to the Medical Costs Finder will in future enable patients to understand past medical charges in anticipation of likely costs for a primary practitioner. Balancing improved information flows with practical difficulties with multiple providers and fee disclosure will be an important consideration.

4.5 Format of financial consent

There is no consistent approach to the format in which fees are disclosed or how IFC is recorded. In some cases, financial information is provided verbally; in others, it may be documented in writing or included in broader consent forms. Verbal discussions may be flexible and context specific but can be difficult to evidence and may be poorly recalled by patients. Written information can support clarity and accountability by providing a record that patients can refer to but may add to the administrative burden of practitioners.

Determining when written IFC is necessary, what level of detail is reasonable, and how information should be presented in a way that is accessible and meaningful to patients is another important consideration.

4.6 Private health insurance complexity

The role of private health insurance (PHI) adds further complexity to the effective operation of IFC. For many patients, the most important financial question is not the total fee charged by individual providers, but the likely gap fee after Medicare and private health insurance benefits are applied. However, determining this amount in advance can be difficult, even for well-informed providers and patients.

PHI products can be complex and highly variable. Benefit levels, exclusions, excesses, co-payments, gap arrangements, hospital agreements and provider agreements differ across insurers/policies and may change over time. As a result, accurately estimating gap fees often requires access to detailed insurance information that may not be readily available to providers at the time consent is sought. Patients themselves may also have limited understanding of their coverage, particularly where hospital costs or multiple provider fees are involved.

4.7 Responsibility for cost information

IFC raises a broader question about where responsibility for cost transparency should reasonably sit. In practice, patients often look to their primary treating doctor, such as the surgeon, to provide an overall indication of likely costs for a procedure, including hospital charges and expected out-of-pocket expenses. However, doctors typically have limited influence over hospital fees, insurance products, or the charges levied by other independent providers involved in an episode of care. These practical issues raise challenges for providing the patient with a clear and reliable estimate of all associated costs. Options, such as requiring the lead practitioner to be responsible for consolidating and accurately conveying all likely associated costs, may represent a change in ordinary practices and increase administrative costs, and liability for that practitioner. The lead practitioner may also be concerned about disclosing fees for other providers over which they have no control and could not be responsible for the fee ultimately charged by those practitioners. Balancing improved information flows for patients with such practical difficulties with multiple providers and fee disclosure will an important consideration.

However, it is of note that that recent Medical Board of Australia (MBA) Guidelines for registered medical practitioners who perform cosmetic surgery and procedures (see point 5.1c) require the lead practitioner to explain the costs of other practitioners involved in the patients care. These Guidelines require the surgeon to disclose, amongst other matters:

- costs of other medical practitioners, for example, assistant surgeon and anaesthetist fees (costs if known, indicative cost or information on how to find out these costs)
- facility costs, for example, theatre fees, and hospital or day procedure centre (costs if known, indicative cost or information on how to find out these costs)
- details of deposits and payments required and payment dates
- possible costs for allied health or other care required post-operatively

Placing the burden solely on patients to navigate insurers, hospitals and multiple providers risks undermining the purpose of IFC and may disadvantage those with lower health or financial literacy.

These tensions highlight a fundamental challenge for IFC frameworks concerned with how to improve patient understanding of likely out-of-pocket costs in a system characterised by fragmented care delivery and complex insurance arrangements, while setting realistic and proportionate expectations about the responsibilities of individual providers versus insurers, hospitals and patients themselves.

4.8 Cultural considerations

In regional and remote locations, where there is limited provider availability, it can make shopping around for specialist services infeasible. Requiring fee disclosure early, at referral and before travel is booked, not just immediately prior to treatment may be preferable for rural patients. It is acknowledged that any measures to strengthen IFC must also support patient choice and reduce harm for First Nations people. Reforms must consider structural inequities, cultural safety and access barriers. For example, digital only solutions may not be sufficient to ensure IFC for all patients. Reforms should enhance patient autonomy by being flexible enough to recognise diverse patient needs, along with support services to provide explanations where connectivity, digital access or literacy are barriers.

4.9 Public hospital patient election

Additional complexity arises for patients receiving care in public hospitals, particularly where they are asked to elect between public and private patient status. Issues have been raised about whether patients fully understand the financial implications of this choice, including potential costs, provider involvement and billing arrangements. This raises questions about how IFC should operate in public hospital settings and how patient election processes can better support informed decision making.

The recently agreed National Health Reform Agreement (NHRA) stipulates a new requirement under J16, whereby election by eligible patients to receive admitted and non-admitted public hospital and health services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after presentation to a hospital or health service and must be made in accordance with the minimum standards set out in the NHRA Addendum.

Under J18, private patients have a choice of doctor, and all patients will make an election based on IFC. IFC is defined as *the provision of cost information to patients, (including any likely out-of-pocket expenses), by a doctor or other health service provider, preferably in writing, about a proposed treatment or admission to hospital or health service*.

J30 outlines that States agree that while patient election forms can be tailored to meet individual State or public hospital needs, as a minimum, all forms will include under (e) a clear and unambiguous explanation of the consequences of private patient election. This explanation should include advice that private patients:

- will be charged at the prevailing hospital rates for hospital accommodation (whether a shared ward or a single room), medical and diagnostic services, prostheses and any other relevant services.

- may not be fully covered by their private health insurance for the fees charged for their treatment and that they should seek advice from their doctor(s), the hospital and their health fund regarding likely medical, accommodation and other costs and the extent to which these costs are covered.
- are able to choose their doctor(s), providing the doctor(s) has private practice rights with the hospital.

5. How is IFC regulated now?

IFC is not currently established 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. This signifies a need to reform to protect consumer interest and reduce provider uncertainty.

The table below illustrates how IFC appears across different legal frameworks, highlighting inconsistencies in definition, responsibility and enforceability.

5.1 Laws and Rules

Overview

Framework	IFC Status	Key Points
Competition and Consumer Act (CCA)	Indirect relevance only	Prohibits misleading or deceptive conduct and false representations about price; does *not* create an explicit requirement for IFC.
Private Health Insurance (Health Insurance Business) Rules 2018	IFC required for declared private hospitals seeking second-tier eligibility	IFC includes written disclosure of expected charges; no enforceable patient rights.
Dental Benefits Rules 2026 (Child Dental Benefits Scheme)	IFC required but undefined	IFC must be obtained before services, no patient remedies.

Table 1.1 — Australian Consumer Law (ACL) Analysis

Act	Sections	Summary
Competition and Consumer Act 2010	**s18**	Prohibits misleading or deceptive conduct in trade or commerce. Applies to health care providers when representing costs or services.
	ss29–30	Prohibit false or misleading representations, including those about price.

Analysis

The Australian Competition and Consumer Commission (ACCC) is responsible for administering Australian Consumer Law in Australia. The ACCC stipulate that medical professionals have an obligation to ensure informed consent by patients and this includes information about the risks, alternative treatment options, consequences of no treatment, post-treatment care and potential complications, as well as charges, including ancillary and add-on costs.

Table 1.2 — Private Health Insurance (Health Insurance Business) Rules 2018.

Element	Details
IFC definition (Rules, Part 1— Definitions)	A hospital makes provision for IFC if it has procedures in place to inform a patient or nominee, in writing, of what hospital charges, insurer benefits and out-of-pocket costs (where applicable) are expected in respect of the hospital treatment.
Application	For scheduled admissions: at earliest opportunity before admission. For other admissions: as soon as reasonably possible after admission.

Analysis

These Rules operate under the *Private Health Insurance Act 2007* and Part2A 7C of the *Private Health Insurance (Health Insurance Business) Rules 2018*, which requires that to be included in the second-tier eligible hospitals class, a hospital must make provisions for informed financial consent. The framework is designed for system level regulation, including some individual patient protections that are included in the assessment criteria.

Table 1.3 – Dental Benefits Rules 2026

Element	Details
IFC definition	No definition of Informed Financial Consent is provided in the Dental Benefits Rules 2026 or the *Dental Benefits Act 2008*.
Requirement	Under the Child Dental Benefits Schedule, dental benefits are not payable unless, before the dental service is rendered, the dental provider informs the person incurring the dental expense of the likely dental benefit payable and any likely

	out-of-pocket costs and obtains and records the person's consent to render the service.

Analysis

The *Dental Benefits Rules 2026* are a legislative instrument made under the *Dental Benefits Act 2008* that set out the detailed operational requirements for the Child Dental Benefits Schedule (CDBS). The Rules specify which dental services attract Commonwealth benefits, who is eligible to provide those services, and the conditions under which dental benefits are payable. Under section 11(c) of the *Dental Benefits Rules 2026*, a dental benefit is not payable in respect of a dental service unless… the dental provider by whom, or on whose behalf, the service is rendered… informs the person incurring the dental expenses in respect of the service of the amount of dental benefit likely payable for the service and any likely out-of-pocket costs before rendering the service; and obtains and records the consent of the person mentioned in paragraph (ii) to render the service.

While IFC is mandatory for relevant dental services, compliance is linked to benefit eligibility rather than patient rights and no direct patient enforcement mechanisms exist. There are however cases where the Professional Services Review (PSR) have considered IFC in relation to the Child Dental Benefit Scheme (see PSR Director's update for May 2025 | Professional Services Review (PSR)). Further information on the PSR is provided in section 6.1 of the paper.

5.2 Professional codes

Overview

Professional codes of conduct set out the ethical and professional standards expected of doctors in their interactions with patients. IFC is widely recognised within these codes as an important element of ethical patient care. There is, however, variation in how IFC is defined, applied and understood by different organisations.

The Medical Board of Australia (MBA), the Australian Medical Association (AMA), and most medical colleges, including the CPMC reference IFC or financial disclosure in some form within their codes or guidance, reflecting its accepted role in supporting informed decision making. However, the way IFC is articulated varies across codes (see Table 1.5). Part of this variation appears to arise from medical colleges developing bespoke approaches to IFC that reflect the specific contexts and risks of their specialties. While this tailoring may be appropriate within specialities, the resulting layers of differing expectations is problematic from a patient perspective. Without a single IFC standard, patients may struggle to understand what their doctor is required to do in relation to IFC, or what is expected of them as participants in cost discussions.

From a practical standpoint, the level of patient engagement in IFC as a collaborative dialogue varies between codes. For example, the patient's role is explicitly defined in the AMA's *Guide to Informed*

Financial Consent.[6] In other codes a doctor's IFC obligation may be satisfied by providing cost information in a more limited or procedural way.

It is notable that all the medical colleges listed in Table 1.5 have co-badged the AMA's Guide, and that all registered doctors are required to comply with the MBA code of conduct, which includes expectations relating to informed consent and communication. This suggests that a single, consistent definition of IFC is capable of being applied across the medical profession. This is further supported by the CPMC Fee Transparency Framework, which consolidated existing ethical principles across 16 specialist medical colleges, reinforcing consistent professional obligations.[7]

The enforceability of professional codes also varies. The MBA's *Good medical practice: a code of conduct for doctors in Australia* is automatically admissible in proceedings under the National Law and may be relied upon when assessing professional conduct. Other professional codes may also be considered for this purpose. In contrast, medical college codes are primarily enforced through internal disciplinary processes, which are outside the scope of this paper. Importantly, the professional codes do not create a legally enforceable right for patients to receive IFC, nor do they clearly identify remedies where IFC is inadequate or absent. Instead, the codes create ethical expectations regarding doctor conduct. Ultimately, these codes do not create an IFC standard which patients can rely on.

How the Codes Differ

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.

[6] Australian Medical Association (AMA). *AMA Guide to Informed Financial Consent 2024*. Australian Medical Association, 10 October 2024.
[7] Council of Presidents of Medical Colleges (CPMC). *Ethical Billing and Fee Transparency: A Medical Specialist Professionalism Framework*. Council of Presidents of Medical Colleges, 2026.

Table 1.5 – Comparison of IFC concepts across different professional bodies

Table 1.5 provides a general comparison of the features of selected professional codes that reference IFC. It highlights how the concept of IFC varies between codes.

College/Organisation	IFC content	Written IFC Required?	Scope of Cost Disclosure	Distinctive Feature	Links
Medical Board of Australia (Good medical practice: a code of conduct for doctors in 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.	No. The code does not require that cost information or consent be provided in writing.	High-level obligation to inform patients of fees and charges; no prescribed level of detail.	Principles-based requirement that does not specify the format, medium, or documentation of cost disclosure.	Medical Board of Australia - Good medical practice: a code of conduct for doctors in Australia
Medical Board of Australia (Guidelines for registered medical practitioners who perform cosmetic surgery and procedures)	The guidelines for non-surgical cosmetic procedures require practitioners to provide information about the risks, benefits and alternatives to the cosmetic procedure. (clause 5.2(c)), and detailed information about costs (clause 5.3), including: • total cost of the procedure • deposits, payment schedules and refund arrangements • costs of follow-up care and maintenance	Yes. The person's clinical consent and financial consent must be obtained, documented, and a copy of the signed consent provided to the person (clause 5.3).	Comprehensive and itemised, covering the full range of treatment-related and associated costs, including future and contingent costs.	Explicit requirement for documented financial consent, with detailed and prescriptive cost disclosure obligations that go well beyond general informed consent requirements. These guidelines only apply to cosmetic procedures (which are generally not covered under MBS).	Medical Board of Australia - Guidelines for registered medical practitioners who perform cosmetic surgery and procedures

College/Organisation	IFC content	Written IFC Required?	Scope of Cost Disclosure	Distinctive Feature	Links
	• potential variability of future costs • possible additional costs for revision or further treatment advice that cosmetic procedures are not covered by Medicare				
Australian Medical Association	The AMA's guidance frames IFC as an ethical and professional dialogue between doctors and patients to ensure patients understand and consent to the fees, rebates and likely out-of-pocket costs associated with medical care. The *AMA Guide to Informed Financial Consent 2024* emphasises transparency about: • the doctor's fees • Medicare rebates • private health insurance benefits • any expected out-of-pocket costs or "gaps", and • possible variations in costs if care changes for clinical reasons	Not mandated. The AMA encourages written IFC (including provision of fee estimates and use of IFC templates), but this is not a binding or enforceable requirement. IFC is described as a process rather than a form, and the guidance is advisory rather than regulatory.	Disclosure focuses on medical fees, Medicare rebates, private health insurance benefits, and out-of-pocket costs, with encouragement to inform patients of likely fees charged by other practitioners involved in their care (e.g. anaesthetists), where practicable. The guidance does not prescribe itemisation or future cost disclosure in the same detail as regulatory guidelines.	An ethics and professionalism based approach to IFC, positioning cost transparency as part of good medical practice and respectful doctor–patient relationships, rather than as a compliance or documentation obligation.	AMA Code of Ethics 2004 AMA Guide to Informed Financial Consent 2024

College/Organisation	IFC content	Written IFC Required?	Scope of Cost Disclosure	Distinctive Feature	Links
Royal Australasian College of Surgeons	RACS lists obtaining IFC as a professional responsibility of all surgeons. The Code of Conducts stipulates under 7.2 that a surgeon will ensure informed consent and Informed Financial Consent are obtained before providing treatment. 7.3 states the surgeon will disclose to patients any interests in matters related to their care, and 7.4 states they will provide information about the likelihood, risks and costs of subsequent or revisional surgery should be required. RACS guidance in the Informed Financial Consent Position Paper (2019) states that surgeons should obtain their patients IFC prior to any medical treatment, where this is practicable. Information regarding a patient's fees and associated recoverable expenses should be given so that a patient can decide whether or not to continue with the procedure and with a specific surgeon.	Not mandated but the RACS position paper recommends that wherever practicable a surgeon's IFC should be written, signed and accepted.	Focuses on surgeon-specific fees	A strong professional expectation that is set out in RACS guidance rather than the Code itself that Informed Financial Consent be obtained before treatment and, ideally, documented in writing as part of good surgical practice.	RACS Code of Conduct 2016 Informed financial consent (2019) | RACS
Australian Society of Anaesthetists	The ASA Position Statement PS04 – Informed Financial Consent defines IFC as a dialogue, which may be verbal or written, that enables a	Not mandated. The ASA considers the "gold standard" for IFC to be a written	Focuses on anaesthetist fees and out-of-pocket expenses.	Outlines how IFC can be facilitated such as Seeing patients in consulting rooms before	ASA PS04 Informed Financial Consent

College/Organisation	IFC content	Written IFC Required?	Scope of Cost Disclosure	Distinctive Feature	Links
	patient to understand the potential fee for the medical procedure. Patients should be informed if the fee will involve out-of-pocket expenses, and their individual financial circumstances should be taken into account.	estimate of the fee (a reasonable range is acceptable), together with a reasonable indication of likely out-of-pocket expenses, provided prior to the day of the procedure, along with written acceptance by the patient.		their admission to hospital. Verbal and written IFC can be obtained. This is ideal. Provision of information in the form of a handout, which surgeons/proceduralists or their staff can give to the patient. This need only detail a reasonable range of potential fees and out-of-pocket expenses. Along with informing patients of fees for the pre-anaesthesia consultation and post-operatively.	ASA PS11 Code of conduct for members
Australian College of Dermatology	The ACD Code of Conduct requires dermatologists to respect patient autonomy and consent, and states that "the level of fees for the consultation and treatment should be available and provided if requested by patients." Dermatologists should be prepared to discuss any estimated fee with the patient, including alerting the patient	Not required. The Code does not mandate written or verbal IFC, nor require costs to be provided proactively.	Fees for consultation and treatment, provided on request. The Code does not require disclosure of rebates or out-of-pocket costs.	A reactive, principles-based approach to cost disclosure: fee information must be available and discussed if requested, but there is no expectation of proactive or written	ACD Code of Conduct

College/Organisation	IFC content	Written IFC Required?	Scope of Cost Disclosure	Distinctive Feature	Links
	to the level of accuracy that is possible. The Code does not define Informed Financial Consent or require proactive disclosure of fees.			informed financial consent.	
Royal Australian and New Zealand College of Psychiatrists	The RANZCP Code of Ethics principle 5 requires that psychiatrists shall seek valid consent from their patients before undertaking any procedure, treatment or provision of a report for legal or other purposes. While the Code does not separately define Informed Financial Consent, costs are addressed as part of the broader informed consent process.	Not required. The Code does not mandate written informed financial consent or specify the form in which cost information must be provided.	Costs as part of consent. Financial considerations, including likely costs, are addressed within the overall consent and treatment discussion rather than as a separate IFC process.	Integrating clinical, ethical, relational and financial considerations within a patient-centred consent framework, rather than prescribing a discrete or documented IFC process.	RANZCP Code of Ethics
Royal Australian and New Zealand College of Radiologists	RANZCR's Guidelines for Informed Consent state that the patient should be given sufficient, clear information regarding his or her likely fees and the associated rebates so that he or she is able to make an informed financial decision prior to the provision of treatment and, where necessary, any alternative ways to access that treatment. Where out-of-pocket expenses are anticipated, information about fees and charges for proposed services	Not mandated. The guidelines emphasise that patients should be advised that fees and charges are estimates only and may change due to unforeseen circumstances. Where fees do change, patients should be advised of any change in writing.	In addition to information on fees and charges, the guidelines indicate that patients should be given general information about billing policies, including when payment will be required, acceptable forms of payment, and appropriate contact	Financial considerations integrated into ethical obligations and formal consent guidance.	RANZCR Code of Ethics Guidelines for Informed Consent

College/Organisation	IFC content	Written IFC Required?	Scope of Cost Disclosure	Distinctive Feature	Links
	should be provided to patients in writing, and a signed acknowledgement of IFC should be sought from the patient prior to commencing treatment.		points for discussing payment issues.		
Council of Presidents of Medical Colleges (CPMC)	The CPMC IFC Framework sets out a structured, patient-centred approach to IFC. It expects patients be provided, before committing to treatment, with clear information about practitioner fees. Medicare and private health insurance rebates. This includes likely out-of-pocket costs.	Required - the framework promotes documented (written) IFC as standard practice, particularly for procedures.	Broad and episode-of-care focused including provider fees, rebates, likely out-of-pocket costs, and coordination across multiple providers where applicable.	Prescriptive and explicitly addresses multi-provider episodes and timing before commitment. Remains voluntary professional guidance (not legally enforceable).	CPMC – Informed Financial Consent Framework)

5.3 National Safety and Quality Health Service (NSQHS) Standards

Under the Australian Health Service Safety and Quality Accreditation Scheme (AHSSQA), public hospitals, private hospitals and day procedure services are required to be accredited to the National Safety and Quality Health Service (NSQHS) Standards. Accreditation against the NSQHS Standards is administered through approved accrediting agencies and is typically a condition of licensing or registration imposed by state and territory regulators. The NSQHS Standards are developed and maintained by the Australian Commission on Safety and Quality in Health Care (the Commission).

NSQHS Action 2.04 requires health service organisations to ensure that their informed consent processes comply with legislation and best practice. This action explicitly encompasses IFC. To clarify assessment expectations, the Commission has issued Advisory AS18/10, which describes how IFC is assessed under the Standards.

For health service organisations treating patients who are accessing private health insurance funding, and the providers working within them, Advisory AS18/10 requires that patients be provided with IFC information in writing, where practicable. This includes:

1. The name of the proposed procedure.
2. The item number for the proposed procedure, if known.
3. The hospital fee for the admission, expressed as a dollar amount where it exceeds the patient's insured rebate.
4. The health insurer benefit, expressed as a dollar amount.
5. Where applicable, estimates of co-payments, including any excess, expressed as a dollar amount.
6. A statement noting where costs are estimates and may vary, including reasons for variation such as length of stay, changes to the procedure performed, or other relevant factors.
7. Where applicable, a statement identifying other service providers who may bill the patient separately, such as surgeons, anaesthetists, assistants, pharmacy or pathology services.
8. Advice that patients should confirm with their health insurer, prior to admission or as soon as practicable afterwards:
   a. the rates of reimbursement applicable to their policy;
   b. whether waiting periods or exclusions apply; and
   c. whether the admission is covered by a no-gap or gap-cover scheme.
9. A space for the patient, or their nominated substitute decision-maker, to acknowledge that they have been informed of and understand the charges.

The NSQHS Standards also incorporate the Australian Charter of Health Care Rights through Action 2.03. The Charter, published by the Commission, recognises a patient's right to receive clear information about the costs of care prior to treatment.[8]

[8] Australian Commission on Safety and Quality in Health Care. *Australian Charter of Healthcare Rights* (Second Edition). ACSQHC, 2019 (updated resources 2020–2021).

The Commission has also developed the National Safety and Quality Cosmetic Surgery Standards as part of national reforms to the cosmetic surgery sector. Cosmetic surgery stands apart from many other health care services in that these services are generally not eligible for Medicare benefits and therefore not covered by any patient protection mechanisms supported through the program.[9] Cosmetic services are usually also delivered as a package by an organisation, rather than a collection of providers who come together for a procedure but bill a patient separately. These Standards emphasise transparency and informed decision making, including in relation to costs, to protect patients from financial and other harms. Accreditation pathways for the Cosmetic Surgery Standards are now in place, either as standalone accreditation or through the NSQHS Standards with an additional Cosmetic Surgery Module.

Collectively, these instruments promote IFC as best practice across health service organisations. However, enforcement operates at a system level through accreditation processes. While failure to meet NSQHS actions may result in adverse accreditation outcomes, including loss or denial of accreditation, the Commission does not investigate individual complaints or resolve billing disputes between patients and health services, as this is typically the role of health services and state/territory governments. As a result, gaps in enforceability remain, limiting direct patient recourse where IFC is inadequate or absent.

6. Current IFC complaint and regulation pathways

In Australia, complaints and regulatory oversight relating to IFC are dispersed across multiple organisations. Each body has a distinct remit, jurisdiction and set of powers, and none are designed specifically to address IFC as a standalone consumer protection issue. This section outlines the principal regulatory and complaint pathways relevant to IFC, with a focus on who or what is regulated, and the types of outcomes that may be available to patients. This analysis highlights the complexity of the current system and the limited availability of patient focused remedies where IFC concerns arise.

6.1 Regulation of practitioners

Medical Board of Australia (MBA) supported by Ahpra

The MBA regulate medical practitioner conduct under the National Law. The MBA is responsible for regulating medical practitioners by developing standards, codes and guidelines as well as by registering medical practitioners and managing notifications relating to professional conduct. They are supported by Ahpra, which administers the National Registration and Accreditation Scheme and provides administrative and policy support to national health practitioner boards.

The MBA receive complaints (notifications) about registered medical practitioners and may investigate matters relating to professional conduct, performance or health. The MBA takes a risk-based approach when it manages notifications and aims to prevent future harm. Anyone can raise a concern (known as a

[9] Australian Commission on Safety and Quality in Health Care. *National Safety and Quality Cosmetic Surgery Standards*. ACSQHC, 2023.

notification) about a registered medical practitioner. This includes patients or family members, other health practitioners, employers or colleagues and/or members of the public. There is no requirement for the person making the notification to be directly affected, and notifications can be made anonymously. A concern can be raised with Ahpra in several ways, including online by 'raise a concern' form, by telephone or via written correspondence. Ahpra's website guides notifiers on whether Ahpra is the appropriate body or whether the matter may be better handled by another organisation (such as a state health complaints entity).

The MBA can take a range of actions after receiving a notification, depending on the seriousness of the matter. For example, it can take immediate action if the Board believes it is necessary to protect public health or safety. Immediate action can include accepting undertakings, imposing conditions or suspending registration. An investigation of a notification may result in referral to a performance and professional standards panel or a responsible tribunal. Potential outcomes of panels and tribunals include cautions, reprimands, the imposition of conditions on registration, suspension or cancellation of registration, or prohibition orders. Many notifications do not reach the threshold for regulatory action and therefore result in no further action.

While the scope is broad, the regulatory framework is focused on public safety rather than on resolving individual patient disputes or providing remedies for financial harm. Ahpra and the MBA do not have mediation or conciliation powers. Matters need to meet a threshold for regulatory action to be taken. Authority for these functions is derived from the *Health Practitioner Regulation National Law Act 2009*.

The independent review of the National Scheme, *Transforming health professions regulation in Australia*, identified significant consumer concerns with the complaints system.[10] The review found that consumers face an overwhelming choice of potential complaint avenues and receive insufficient assistance to identify the most appropriate pathway. Consumers are often required to navigate between Ahpra, health service providers and state and territory health complaints entities to have their concerns addressed. The review also highlighted dissatisfaction with the high proportion of notifications that result in no further regulatory action, as well as the lack of clarity for complainants about likely outcomes at the outset of the process.

Professional Services Review (PSR)

The PSR Scheme 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, 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.

[10] Department of Health and Aged Care. *Transforming Health Professionals' Regulation in Australia: Independent Review – Final Report*. Australian Government, 2025.

Sanctions available under the PSR Scheme 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.

Although IFC obligations are sometimes discussed in the context of Medicare billing, the PSR's review is limited under the Health Insurance Act to MBS and CDBS billing and pharmaceutical benefits prescribing behaviours. IFC cannot be enforced through PSR mechanisms, and the Scheme is not designed to address individual patient complaints.

State and Territory Health Complaints Entities (HCEs)

State and territory HCEs manage complaints about health services, including those involving registered and unregistered practitioners and health organisations operating within their jurisdiction. These bodies may seek to resolve complaints locally, make comments or recommendations, refer matters to professional councils or regulators, or escalate serious matters for investigation.

While HCEs provide an important avenue for complaints about health services, their powers and processes vary by jurisdiction, and their remit is limited to their respective state or territory. While some jurisdictions including Victoria, Western Australia, Queensland and South Australia specifically identify IFC within their remit and actively investigate IFC related complaints, other jurisdictions such as New South Wales point people to the Private Health Insurance Ombudsman, Office of Fair Trading and Department of Health for assistance with issues related to fees in healthcare.

The number of IFC-related complaints reported by HCEs varies widely, ranging from as few as seven complaints over a two-year period in one jurisdiction to more than 3,000 complaints over a five-year period in others. This variation may reflect a range of factors, including differences in remit, how IFC is defined, reporting practices, and available resources.

Outcomes are often focused on service improvement or regulatory referral rather than compensation. Where IFC concerns involve financial loss, patients may need to pursue separate legal action to seek reimbursement. As a result, processes can be complex and outcomes for patients uncertain.

6.2 Regulation of hospitals

The Australian Commission on Safety and Quality in Health Care oversees accreditation of hospitals and health services through the Australian Health Service Safety and Quality Accreditation Scheme, which assesses compliance with the National Safety and Quality Health Service (NSQHS) Standards. Persistent non-compliance can result in loss of accreditation, licensing consequences, or impacts on funding.

While the NSQHS Standards and the Australian Charter of Health Care Rights include expectations around the provision of information to patients, including information about costs, the Commission's

role is primarily systemic and periodic. It does not investigate individual complaints or provide direct remedies to patients, and the Charter does not define IFC in detail or create enforceable individual rights. The Commission's authority derives from the *National Health Reform Act 2011*.

6.3 Private Health Insurance Ombudsman (PHIO)

The PHIO handles complaints relating to private health insurance arrangements under the *Private Health Insurance Act 2007*. The PHIO's jurisdiction operates under the *Ombudsman Act 1976*. The PHIO may investigate complaints, facilitate mediation, and report systemic issues to the Minister for Health.

The PHIO's remit is limited to private health insurance matters and does not extend to regulating provider billing practices or enforcing IFC obligations. As such, it has limited scope to provide direct remedies to patients where adequate financial consent has not been obtained. The PHIO can however liaise with parties (including medical professionals and hospitals) about the provision of IFC.

The PHIO publish a Quarterly Update on the number of complaints and subtypes that are received each quarter, and IFC is listed as a standalone category. The Quarterly Update for July-November 2025 indicated that there were approximately 30 complaints per year relating to IFC.

6.4 Regulation of businesses

Patients who feel that they have not been provided with sufficient information on health care costs prior to a service could, theoretically, pursue the matter through consumer protection channels such as Australian Consumer Law (for example, where a doctor's conduct may be misleading or deceptive) or contract law (where there was no agreement to pay the fee charged). Pursuing either pathway is time-consuming and procedurally complex. Depending on the amount in dispute, a patient would need to commence either a minor civil claim or a general civil claim in the Magistrates Court. This typically requires preparing and sending a letter of demand, filing formal court documents, gathering evidence, and attending court proceedings. Even in lower value matters, patients must pay upfront filing fees and face some risk of adverse costs if unsuccessful and may incur legal costs if they seek professional advice. Taken together, these procedural, financial and evidentiary hurdles mean that civil litigation is not a practical or accessible remedy for most patients seeking redress for failures to provide IFC.

Case Law

The website of medical indemnity insurer Avant has referenced case law examples relevant to informed financial consent. In one case cited, it was indicated that, in the absence of prior agreement, practitioners may face difficulty recovering fees above the Medicare Benefits Schedule (MBS) amount. The advice emphasised that if a practitioner intends to charge above the MBS scheduled fee, the patient must be informed before treatment proceeds. Where no fee is agreed and the patient is not aware of any potential gap payment, a court may imply the MBS scheduled fee as the reasonable fee payable. In these circumstances, the practitioner would not be entitled to recover more than the scheduled fee, regardless of whether the higher fee might otherwise be considered reasonable. In that case, the claim

for the additional fee above the MBS scheduled fee was dismissed, with the court finding that no further payment was recoverable.[11]

The Avant website also referenced that a tribunal case highlighted that failures in IFC can arise alongside broader issues with clinical and billing practices, reinforcing its importance as part of professional conduct. In one case, a practitioner was found to have engaged in unprofessional conduct, including overservicing and failing to obtain appropriate financial consent from a vulnerable patient. Analysis emphasised that obtaining IFC is a critical component of the consent process, requiring clear communication of all fees and charges before services are provided, and where necessary, consent must be obtained from an appropriate substitute decision-maker. The case also underscored that inadequate documentation and lack of transparency around services and billing can exacerbate regulatory risk, demonstrating that IFC is not only about fee disclosure, but forms part of broader obligations relating to patient communication, ethical practice and accountability.[12]

ACCC

The Australian Competition and Consumer Commission (ACCC) enforce Australian Consumer Law under the *Competition and Consumer Act 2010*, which applies to all businesses, including medical practices operating as businesses. The ACCC may investigate misleading or deceptive conduct, including practices such as hidden fees or drip pricing, and can seek penalties, injunctions and other remedies through court proceedings. In practice, the ACCC prioritises matters involving systemic or widespread consumer harm. Resource constraints, limited precedent in health care billing disputes, and the focus on enforcement rather than individual redress limit the effectiveness of the ACCC as a practical complaint pathway for individual IFC disputes.

6.5 Summary of complaint pathways

Although IFC features across multiple regulatory frameworks, it is not established as a clear, legally enforceable right. Patients seeking to raise concerns about IFC are required to navigate a complex system involving multiple regulators, none of which are designed to provide a single, accessible entry point or to guarantee meaningful remedies for financial harm.

Key Issues:

- Fragmentation: multiple regulators with overlapping but incomplete powers.
- No clear pathway: consumers lack a single point of entry for IFC disputes.
- High burden: patients must navigate complex legal and administrative systems.
- Limited remedies: even successful complaints often do not guarantee refunds.

[11] Prior agreement required to charge more than Medicare fee - Avant
[12] Doctor found guilty of unprofessional conduct for overservicing and not gaining financial consent - Avant

7. Split billing and hidden costs

7.1 What is split billing?

While IFC focuses on the adequacy of information provided to patients before care, split billing is a billing practice that can actively undermine IFC by fragmenting cost information across multiple invoices and payers.

This paper considers split billing alongside IFC as both issues relate directly to financial transparency and practitioner conduct in relation to patient fees. Both these areas offer opportunities to improve patient-centred outcomes through more transparent billing practices. Options to strengthen prohibitions on split billing can, and should, be developed in parallel with measures to strengthen IFC protections for consumers.

Split billing involves separating elements of a single episode of care across different billing arrangements, with the effect of obscuring the true cost of that service from one or more payers. These are typically presented as admin or booking fees.

A 2026 report by Private Healthcare Australia (PHA)[13] reported that:

- 29% of patients said they were charged "administration" or "booking" fees for specialist appointments.
- 18% of patients reported being asked to pay non-refundable deposits before their appointment.
- Consumers could be paying $20M in hidden fees and upfront deposits, though the full magnitude of hidden costs is unknown.

Examples where split billing can be used to obscure health care costs and increase out-of-pocket costs to patients could include:

- Providers claiming a bulk billing incentive while separately charging the patient a booking fee, admin fee or membership fee. Not only does a patient incur out-of-pocket costs for a service which should be free, but their costs also do not count towards their Medicare Safety Net threshold (where an eligible service is provided out-of-hospital).
- Providers with no/known gap arrangements with a health insurance provider enhance the value of private health insurance by reducing patient out-of-pocket costs and improving transparency. However, these arrangements can be undermined when providers separately charge their patient a fee such as an admin or booking fee. Circumventing these arrangements restricts the value of insurers entering into agreements with providers to lower health care costs.

Split billing can occur due to the presence of multiple payers within the health care system, typically the patient, the patient's private health insurer, and the government through mechanisms such as the Medicare Benefits Schedule (MBS), who do not routinely share billing information with one another.

[13] Mandala Partners & Private Healthcare Australia. *Restoring Affordable Access to Specialist Care in Australia*. Private Healthcare Australia, February 2026.

These structural features can reduce transparency and blur accountability for patients. As these payers operate largely in isolation, practitioners can use gaps in oversight to increase revenue through practices such as split billing. In effect, the full cost of care is not transparently disclosed to all relevant parties. These hidden charges contribute to out-of-pocket costs that are not captured in official reporting, undermining efforts to accurately measure and reduce cost pressures in the private health system.

The CHF report 'Health consumers' experiences and perceptions of healthcare costs' also highlighted that hidden costs demonstrate that the issue with high costs is not just the total amount charged, but the lack of transparency and clarity in cost. The report found that medical specialists were the hardest to obtain pricing from, followed by hospitals, suggesting that the most expensive and complex services, can also be the least transparent.

7.2 Split billing regulation and complaint pathways

There is some legislative prohibition on split billing in Australia. If a patient has been bulk billed and assigned their Medicare benefit to the practitioner, the patient will be charged nothing. For example, the Health Insurance Regulations 2018 requires that expenses levied by the provider should be recorded on the account or receipt or benefit. However, this requirement may be circumvented if the provider either knowingly or mistakenly does not think that a charge is medical and therefore not captured by this rule.

For those services not bulk billed, relevant protections may arise under the Australian Consumer Law (ACL), including prohibitions on misleading or deceptive conduct, drip pricing, and hidden fees. However, the applicability of these provisions in medical billing contexts remains unclear and largely untested.

Private Healthcare Australia has called for stronger regulatory action, including legislated penalties for split billing. The AMA has described the use of split billing to avoid private health insurance agreements as "inappropriate" and does not support the practice (AMA Position Statement, clause 1.7).

Key ACL principles include:

- Businesses must not engage in misleading or deceptive conduct.
- Consumers must be made aware of the total price payable, including any unavoidable fees or surcharges, before deciding to purchase goods or services.

As discussed earlier in the paper with IFC, the ACCC enforces the ACL under the *Competition and Consumer Act 2010*. The ACL applies to all businesses, including medical practices. Private practitioners are considered businesses and must not engage in misleading or unconscionable conduct, including in relation to pricing and cost disclosure.

The ACCC can receive complaints, investigate conduct, and bring enforcement action, including seeking penalties and injunctions. However, in terms of split billing, there is a lack of precedent specifically involving medical practitioners, and the absence of clear consumer remedies where it

occurs. While there is no established precedent of the ACCC prosecuting individual doctors for split billing, it has taken significant enforcement action in health-related contexts.

8. Options for reform

The table below highlights some potential ways that IFC and split billing regulation reform could be explored. The inclusion of these options does not imply government has agreed to reform IFC or split billing or that it has signified a preferred approach. Rather, these options are presented to illustrate a range of possible options that could be considered if reform was agreed to, in order to receive stakeholder feedback (see questionnaire at 9).

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 auditability, definitional clarity, and reduce clinical uncertainty. These factors may limit the practicality of some regulatory approaches. This will be considered as part of stakeholder consultations in mid/late 2026.

Table 2: Potential options for regulating IFC

Option	Description	Pros	Cons
Expand function of Professional Services Review	Explore amendments to the Health Insurance Act 1973 to establish clearer IFC obligations (including split billing practices), supported by broadening the scope of the PSR Scheme to give PSR the authority to review the conduct of practitioners who have engaged in 'inappropriate practice' in failing to obtain IFC prior to treatment. Outcomes could include MBS rebates being paid back when IFC is not obtained and limitations on claiming MBS for a period of time for repeat offenders. Specific monetary penalties on providers could also be considered.	• Creates a clear Commonwealth legislative basis for IFC • Leverages existing Medicare compliance infrastructure (or PSR adjacent mechanisms) • Signals IFC as a core Medicare integrity issue • Can be targeted to Medicare funded services	• Enforcement may remain indirect, with sanctions focused on Medicare access rather than patient remedies • Current PSR processes have been designed to review Medicare billing and patterns of behaviour over a period of time, rather than IFC. This would be a significant change requiring additional powers and change in scope

Option	Description	Pros	Cons
			• Risk of perceived compliance burden on providers • Potential for unintended impacts if sanctions restrict Medicare billing such as opting out of the MBS (resulting in higher out-of-pocket costs to patients) or impacting accrual of funds for the Extended Medicare Safety Net purposes. • Legislative change required • No ability to deliver direct patient compensation • Additional resourcing needed for PSR to support new role • Only applies to a service for which a Medicare rebate is paid/payable
Expand the role of the Department of Health, Disability and Ageing compliance mechanisms	Explore amendments to the *Health Insurance Act 1973* to establish clearer IFC obligations (including split billing practices), supported by the Department of Health, Disability and Ageing's internal audit team, who would monitor and undertake compliance action where requirements are not met.	• Creates a clear Commonwealth legislative basis for IFC • Leverages existing compliance infrastructure within the Department • Signals IFC as a core compliance integrity issue, not merely a professional standard • Can be targeted to Medicare funded services	• Current penalties under the Act are not designed for consumer redress • No ability to deliver direct patient compensation • Risk of perceived compliance burden on providers • Only applies to a service for which a Medicare rebate is paid/payable

Option	Description	Pros	Cons
	Complaints could be raised via a departmental 'tip off' telephone line or via a dedicated email address. Outcomes could include MBS rebates being paid back when IFC is not obtained, limitations on claiming MBS for a period of time for repeat offenders or consideration of infringement notices.		• Potential for unintended impacts if sanctions restrict Medicare billing such as opting out of MBS (resulting in higher out-of-pocket costs to patients) or impacting accrual of funds for the Extended Medicare Safety Net purposes • Legislative change required • Requires additional funding to staff the new functions
Ahpra and/or health complaints agency enforcement of IFC using National Law Provisions	Examine whether IFC obligations (including split billing practices) could be strengthened and enforced through the *Health Practitioner Regulation National Law*, including via Ahpra and health complaints entities. Complaints could be raised through existing channels such as to Ahpra and health complaints entities. Similar outcomes would exist to current practice e.g. if there is misconduct, standard Ahpra processes and sanctions would be followed.	• Creates a nationally consistent framework across professions • Utilises existing complaints and regulatory pathways • Reinforces IFC as part of professional conduct expectations • Utilises existing regulatory body • Could extend beyond services funded through the MBS	• National Law is not designed for consumer redress • Processes can be resource intensive • Outcomes focus on practitioner regulation, not patient compensation • Would require all states and territories to agree to amend their legislation • Health complaints entities currently vary with IFC remit and change will require all jurisdictions to agree on an agreed IFC approach • Would only apply to health professions that are regulated through the National Law • In the current system where health complaints agencies can investigate IFC

Option	Description	Pros	Cons
			related complaints, low numbers result in an outcome for the patient
Establish a new regulator to investigate IFC complaints	Establish a dedicated statutory authority, consistent with constitutional advice, with powers to receive, investigate and resolve IFC and split billing complaints. The regulator would be designed specifically to address non-compliance, with investigatory powers similar to those of Commonwealth complaints bodies (for example, Ombudsman-style powers). Its remit would focus on IFC obligations rather than broader professional conduct.	• Creates a clear, consumer-focused complaint pathway for IFC • Designed specifically for IFC, allowing clearer standards and lower thresholds than professional misconduct regimes • Potential to deliver patient-centred remedies (not just disciplinary outcomes) • Establishes a nationally consistent framework • Signals IFC as a substantive consumer protection obligation	• Requires new legislation and significant establishment and ongoing resourcing • Risk of duplication with existing regulators (Ahpra, state and territory health complaints entities, consumer law bodies) if roles are not clearly defined • Complex legislative design required to ensure constitutional validity and appropriate powers • Longer lead time to implement compared with adapting existing frameworks
Expand existing regulators such as the Australian Competition and Consumer Commission (ACCC) to enforce IFC obligations	Explore whether existing provisions under the Australian consumer law, administered by the ACCC and state and territory consumer regulators, could be applied or clarified to address inadequate disclosure of medical costs (including split billing practices). This could include treating failure to provide adequate upfront cost information as misleading or	• Likely more cost effective than setting up a new regulator • Utilises an existing national consumer protection framework • Potential to deliver consumer remedies, including compensation in some cases	• Generally high evidentiary thresholds for proving misleading or deceptive conduct • Enforcement is typically not designed for high-volume individual complaints • May not capture all IFC failures (e.g. timing/format of disclosure may not clearly breach consumer law)

Option	Description	Pros	Cons
	deceptive conduct, or a failure to provide services with due care and skill.	• Applies beyond MBS-funded services (captures privately funded care) • Strong investigative and enforcement powers already exist	• May require test cases or regulatory guidance to establish precedents
Education, guidance and voluntary compliance (no legal change)	Continue to promote IFC through patient and provider education, including culturally safe design, professional guidance, training, and voluntary tools such as Medical Costs Finder	• Lower cost and lower regulatory burden • Builds on existing professional support and goodwill • Avoids legal and implementation risks • Can be implemented quickly in a phased approach • Can be targeted to both patients and providers to encourage better practices	• Evidence suggests voluntary approaches have not delivered consistent change • Uptake remains low and uneven • No enforceability or accountability mechanisms • Does not address hidden fees or poor disclosure practices • Fee transparency through tools such as the Medical Costs Finder may, in some cases, contribute to upward pressure on fees.

9. Implications for reform

Many of the challenges outlined in this paper underscore the need for greater clarity and consistency in how IFC is understood and applied by patients, practitioners and regulators. The view of this paper is that these challenges should not be seen as reasons to avoid reform, but rather as design considerations that can inform more effective policy responses.

Strengthening IFC, particularly through approaches that support two-way communication and shared decision-making, has the potential to improve patient experience, support better decision-making, and foster shared responsibility for the delivery of health care.

The challenges highlight that while IFC is widely supported in principle, there is no consensus on how IFC should be defined, implemented or enforced in practice.

To inform the development of practical, proportionate and effective options for reform, this paper seeks views on the following questions.

10. Questionnaire

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 included in the appendix.

Submissions close on Wednesday 5 August 2026. Thank you for your interest in this important matter.

Appendix 1 – copy of survey questions

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?