



Private Healthcare Australia

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Fee transparency in health care - Informed financial consent and split billing practices

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have more than 20 registered health funds throughout Australia as members and collectively represent 99% of people covered by private health insurance. PHA member funds provide healthcare benefits for more than 15 million Australians.

Introduction

Private Healthcare Australia (PHA) welcomes the opportunity to contribute to the Australian Government's consultation on strengthening informed financial consent (IFC) and addressing split billing practices within the private healthcare system.

Current practices, including high costs, a lack of transparency and deceptive billing tactics are preventing Australians from accessing health care. This must change, and PHA recommends a suite of measures to ensure consumers are better protected.

In 2024-25, more than 480 million services were billed through Medicare.¹ PHA notes that most doctors do the right thing, but even a small proportion exhibiting poor billing behaviour – intentional or otherwise – means thousands of Australians are adversely affected each week.

Informed financial consent – knowing how much a service will cost in advance – is a vital part of good medical practice.

Patients should be able to make informed decisions about their treatment with a clear understanding of the likely financial implications before treatment begins. Transparency and certainty regarding healthcare costs are essential to supporting consumer choice, maintaining confidence in the private health system, and protecting patients from unexpected financial hardship.

The importance of IFC is recognised across Australia's health system, with clinical leaders and organisations suggesting policies are generally sound. However, there is significant variation in how professional medical bodies define and implement IFC requirements, including differences in expectations relating to cost disclosure, timing, documentation, and whether fees charged by other providers involved in a patient's care should be disclosed by the lead practitioner. These inconsistencies contribute to variable patient experiences and undermine the transparency and predictability that consumers reasonably expect.

Enforcement is non-existent. There are no penalties for poor practices, other than those paid by patients – either through paying more than they expected for services, or worse, not seeking care because of the fear of high and unexpected costs.

The consequences of inadequate IFC are increasingly evident. Recent research commissioned by PHA found 30% of Australians have delayed or cancelled specialist treatment because of the anticipated cost.² These findings reflect broader concerns across the health system about the affordability and transparency of private specialist care. Independent analysis has found that

¹ Services Australia (2026), [Annual report](#), Snapshot, p. iii

² RedBridge (2025), [Experiences with medical specialist and surgeon fees](#), p.6

almost 1.9 million Australians delay or forgo specialist treatment annually due to cost, while consumer organisations have consistently identified specialist fees and unexpected out-of-pocket expenses as major barriers to accessing timely care.³

Many patients are not receiving the information they need to make informed decisions about treatment. One-in-three Australians (36%) reported they did not receive sufficient information about the likely costs of specialist treatment to plan effectively, while fewer than half (44%) knew the cost of their specialist appointment before attending.⁴⁵

As a result, unexpected costs remain common. More than one-third of Australians (38%) reported receiving an unexpected medical bill, and over half (55%) said they were ultimately charged more than they had anticipated.⁶

Certain billing practices further contribute to the lack of transparency around treatment costs. Split billing – when costs associated with a single episode of care are divided across multiple bills or charging mechanisms is designed to deceive patients, government and insurers for personal gain. It should be prohibited. Split billing can be used to avoid reporting actual costs to governments to falsely claim bulk-billing incentives or to split services across multiple days to avoid applicable billing rules. It can also be used to claim additional money from insurers for “no-gap” and “known gap” arrangements, while still billing patients outside of those contractual arrangements.

Such arrangements can obscure the true cost of treatment, increase patients’ out-of-pocket expenses, and potentially circumvent Medicare or private health insurance requirements. They may also be unlawful. More broadly, charging patients fees unrelated to their care appears to be common practice. Nearly one-third of Australians (29%) reported being charged an administration or booking fee unrelated to their care, while 18% said they were required to pay a non-refundable deposit to secure an appointment with a medical specialist.⁷

PHA welcomes the Australian Government’s ongoing investment in fee transparency initiatives, including enhancements to the Medical Costs Finder website. Publicly available information on specialist fees and out-of-pocket costs can help consumers better understand healthcare costs and identify variations in charging practices.

However, general pricing information cannot substitute for provider-specific informed financial consent. Patients require timely, personalised information about the likely costs of their treatment path before making decisions about care. Strengthened IFC requirements should therefore be viewed as a complementary reform that builds on, and enhances, the benefits of Medical Costs Finder.

The evidence demonstrates that the current IFC measures are not delivering the transparency, consistency and certainty that Australian patients need.

³ Grattan Institute (2025) [Special treatment: Improving Australians’ access to specialist care](#)

⁴ Mandala Partners (2023) [Restoring Affordable Access to Specialist Care in Australia](#), prepared for Private Healthcare Australia, p.19

⁵ Ibid

⁶ Ibid, p.33

⁷ Ibid. Note, separate charges which are subsequently appropriately reported to Medicare and health funds as part of the charges for the service do not circumvent any rules or contractual arrangements.

PHA supports the introduction of a nationally consistent, legally enforceable IFC framework that establishes clear obligations on providers, protects consumers from unclear and unfair billing practices, and clearly articulates patients' rights.

PHA has consistently advocated for stronger consumer protections in this area. Since 2022, PHA has called for Australia to adopt protections similar to those implemented in overseas jurisdictions, including approaches that ensure patients are not liable for costs that were not properly disclosed to them before treatment.

The framework should be supported by proportionate compliance and enforcement mechanisms, meaningful sanctions for non-compliance, and public reporting of enforcement outcomes to promote accountability and deter poor practice.

PHA recommends that the framework be underpinned by the following principles:

1. Establish enforceable consumer rights through a nationally consistent informed financial consent standard.
2. Protect patients from surprise billing by ensuring they are not liable for costs that were not disclosed before treatment.
3. Require written informed financial consent for all planned private healthcare services.
4. Require providers to give patients a written estimate of the total expected cost of an episode of care, wherever reasonably practicable, within a specified timeframe after treatment is booked.
5. Prohibit hidden fees, split billing and other billing practices that obscure the true cost of an episode of care.
6. Provide effective compliance, enforcement and consumer redress mechanisms where informed financial consent obligations are breached.
7. Introduce proportionate regulatory sanctions for non-compliance with informed financial consent requirements.
8. Publish compliance and enforcement outcomes to promote transparency, accountability and continuous improvement.

These reforms would strengthen consumer confidence in the private health system by delivering greater transparency, consistency and accountability, ensuring patients can make informed decisions about their healthcare with greater confidence and certainty.

Response

Adequacy of Existing Professional Standards

Do existing professional codes of conduct provide sufficient clarity on IFC?

Existing medical professional codes of conduct, guidelines and ethical standards recognise the importance of IFC, but they do not provide sufficient clarity, consistency or enforceability to ensure patients receive comprehensive and meaningful information about the likely costs of their care.

As the consultation paper demonstrates, medical boards, specialist colleges, professional associations and other healthcare organisations generally encourage providers to discuss fees and obtain financial consent before treatment. However, there is considerable variation in the content, scope and expectations of these requirements. As a result, patients are experiencing very different standards of cost disclosure depending on the provider, profession, specialty or treatment setting involved.

A key limitation of the current framework is the absence of a consistent definition of what IFC requires in practice. Different professional bodies also provide differing guidance regarding:

- what cost information should be disclosed
- how detailed that information should be
- whether cost information must be provided verbally, in writing or both
- when disclosure should occur
- whether likely out-of-pocket expenses should be identified
- whether costs charged by other practitioners involved in treatment should be disclosed, and
- what documentation should be retained to demonstrate compliance.

This variability creates uncertainty for both consumers and providers. Patients cannot be confident that they will receive the same level of financial transparency across different areas of the health system, while providers may be unclear about the minimum standard expected of them.

The existence of widespread consumer concerns regarding unexpected medical costs and inadequate fee transparency also suggests that existing professional guidance has not been sufficient in delivering consistent outcomes. If current professional standards were operating effectively on their own, issues relating to surprise billing and inadequate cost disclosure would be less prevalent. The persistence of these concerns indicates that reliance on ethical expectations and voluntary compliance has not achieved the desired level of consumer protection.

Another significant weakness of the current approach is that professional organisations' standards are not legally enforceable and do not provide consumers with practical remedies where IFC is absent or inadequate. While professional regulators may investigate serious conduct issues, patients often have limited avenues for redress where they receive unexpected

bills after treatment. In practice, consumers frequently bear the burden of resolving disputes and navigating complex complaints processes, even where inadequate financial disclosure has occurred.

The consultation paper also highlights important inconsistencies between professional standards. For example, the Medical Board of Australia's [*Guidelines for registered medical practitioners who perform cosmetic surgery and procedures*](#) imposes relatively detailed obligations regarding cost disclosure, including information about hospital fees, anaesthetist costs, assistant surgeon fees and other expenses associated with an episode of care. These requirements recognise that meaningful financial consent extends beyond the fees charged by the primary practitioner alone.

In contrast, disclosure requirements in other areas of private healthcare are often less comprehensive. One example is the approach commonly adopted in relation to anaesthetic services. Anaesthetists are frequently the source of patient complaints about unexpected out-of-pocket costs, yet existing professional guidance does not ensure that patients receive information about anaesthetic fees at the same time they receive information about surgical costs.

The [*Australian Society of Anaesthetists policy on informed financial consent*](#) describes written notification of fees before the day of the procedure as a “gold standard”. However, where fee information is only provided shortly before surgery, patients may have already committed considerable time, effort and expense to arranging treatment, including specialist consultations, pre-operative testing, leave from work and hospital bookings. In these circumstances, patients have limited practical ability to compare providers, negotiate fees or make alternative treatment arrangements. Although financial consent may technically be obtained before treatment proceeds, in such circumstances, it does not necessarily provide patients with a meaningful opportunity to make an informed financial decision. For anaesthetic services, patients do not select the anaesthetist anyway, and generally only receive fee information after committing to a procedure recommended by their surgeon.

In addition, anaesthesia is not optional – it is a vital part of surgery, and if the fee is only disclosed the day before surgery, the only option the patient has is to pay the requested amount or cancel the surgery. Thus, consent is being sought under duress.

More broadly, where a surgeon is unable to disclose the likely fees of other practitioners involved in an episode of care, including the anaesthetist, the patient is only being advised of part of the total cost of treatment. This falls short of the objective of IFC, which should enable patients to understand, as early as reasonably practicable, the expected cost of their entire episode of care.

Requiring patients to progressively discover additional costs as their treatment approaches can have a similar effect to “drip pricing”, whereby the full price of a service only becomes apparent after a consumer has already made a commitment to proceed. In healthcare, the consequences can be particularly significant, with additional charges potentially amounting to hundreds or thousands of dollars and patients facing substantial practical barriers to withdrawing from treatment at a late stage.

The existence of more comprehensive disclosure practices for self-funded surgery demonstrates that higher standards of financial transparency are both practical and

achievable. It also raises questions about why consumers undergoing other forms of private healthcare should receive a lower level of financial protection.

Professional codes and guidelines remain important and should continue to play a role in supporting good practice. However, they are best viewed as supplementary to, rather than a substitute for, a nationally consistent IFC framework. Professional standards can assist providers in implementing IFC obligations, but they cannot deliver meaningful consumer protections where the underlying requirements differ across professions and organisations, and there is no enforcement.

A nationally consistent IFC framework would establish clear minimum requirements that apply across the private healthcare system. It would clearly define the information patients are entitled to receive, establish consistent expectations regarding timing and documentation, and provides the basis for enforceable consumer rights where obligations are not met. Professional bodies could then build upon these minimum standards through profession-specific guidance that reflects the unique circumstances of different specialties and practice settings.

Scope of cost disclosure requirements – including those that eliminate split billing

Should IFC require disclosure of total episode-of-care costs, including separately billed services?

True informed financial consent should require disclosure of the total expected cost of an episode of care, wherever practicable, including separately billed services provided by other practitioners or organisations involved in the patient's treatment.

Patients experience healthcare as a single episode of care rather than as a series of separate commercial arrangements between individual providers. When consumers are deciding whether to proceed with treatment, they are primarily concerned with understanding the likely overall financial impact, including potential out-of-pocket expenses, not simply the fee charged by the surgeon or lead practitioner. Limiting disclosure to the costs directly billed by an individual provider does not provide patients with the information necessary to make fully informed decisions.

Currently, many patients receive separate invoices from surgeons, anaesthetists, assistant surgeons, pathology providers, radiology providers, the hospital where the procedure takes place, among others. While each provider may only be responsible for a portion of the overall cost, patients ultimately bear the financial consequences of the entire episode. Requiring disclosure of only one component of the total cost risks creating a misleading impression of the total financial commitment involved.

A key objective of IFC should be to reduce unexpected medical bills and improve fee transparency. That objective cannot be fully achieved if significant known or reasonably foreseeable costs are excluded from the information provided to patients before treatment. Consumers cannot provide genuine IFC where they are aware of only part of the likely cost of care.

Importantly, requiring disclosure of total episode-of-care costs does not mean requiring any individual practitioner to guarantee the fees charged by other providers. Nor should providers be held responsible for costs that are genuinely unknown or incapable of being reasonably estimated at the time consent is obtained. Rather, providers should be expected to make reasonable efforts to disclose known costs, provide indicative estimates where available, identify potential areas of uncertainty, and advise patients how they can obtain more detailed information from other providers if necessary.

Where precise costs are unavailable, the framework should permit the use of reasonable estimates, cost ranges or indicative pricing, provided any assumptions or uncertainties are clearly explained. Patients generally understand that healthcare costs may vary depending on clinical circumstances. What consumers seek is not a guarantee of the final price, but a reasonable understanding of the likely financial implications of proceeding with treatment.

To help achieve this, the framework should require providers to disclose, wherever reasonably practicable:

- the provider's own fees and expected out-of-pocket costs (including a breakdown by MBS item numbers)

- known costs charged by other practitioners or organisations involved in the episode of care (including a breakdown by MBS item numbers)
- reasonable estimates or cost ranges where exact amounts are unavailable
- any material uncertainties that may affect final costs
- information about Medicare and private health insurance rebates, where known, and
- guidance on how patients can obtain further cost information from participating payers and providers.

A reasonable practicability test should apply where providers genuinely do not have access to information held by another practitioner. However, it is worth noting that many medical specialists often use the same teams most of the time, so the costs of these services should be predictable.

A further practicability test should apply where the patient is not given a choice of practitioner, for example an anaesthetist, assistant surgeon, pathologist or radiologist. If a medical practitioner is choosing members of the care team rather than the patient, that surgeon should take on responsibility for estimating IFC for their colleagues' work.

For example, many public hospitals ask patients to elect to be treated privately and tell those patients they will not be charged for accommodation, meals, nursing care and other services. These disclosures may not include the possibility that patients may be charged out-of-pocket fees for medical services. Around one in three patients who elected to be private patients in public hospitals received an out-of-pocket cost in 2022-23.

Another common example is pathology and diagnostic imaging. Patients are often surprised to receive an out-of-pocket cost for these services following a medical procedure. In most cases the charges are entirely predictable and should have been disclosed to the patient beforehand.

The existence of multiple providers should not, in itself, excuse incomplete disclosure. Providers involved in planned private treatment should be expected to cooperate in supporting transparent cost disclosure and helping patients understand the likely total cost of care.

Ultimately, IFC should focus on the information that patients need to make informed choices, rather than the administrative boundaries between providers. Requiring disclosure of total episode-of-care costs, including separately billed services wherever reasonably practicable, would significantly improve fee transparency, reduce the incidence of unexpected medical bills, and strengthen consumer confidence in the private healthcare system.

Providers subject to IFC obligations

Who should IFC obligations apply to?

IFC obligations should apply to all healthcare providers and organisations that charge patients directly for services associated with private healthcare. A comprehensive IFC framework must reflect the reality that healthcare costs are often generated by multiple providers across a single episode of care. Limiting obligations to particular professional groups would create gaps in transparency and undermine the effectiveness of the framework.

At a minimum, IFC obligations should apply to:

- medical specialists and surgeons
- general practitioners where private fees are charged for referred or procedural services
- anaesthetists
- assistant surgeons
- hospitals and day procedure centres
- pathology and diagnostic imaging providers
- allied health practitioners providing privately billed services
- nurse practitioners and other independently billing health practitioners, and
- any other healthcare provider that charges patients directly for care.

The primary objective of IFC should be to ensure that patients receive clear, timely and meaningful information about the likely costs of treatment before financial commitments are incurred. From a consumer's perspective, it is irrelevant whether costs originate from a specialist, hospital, anaesthetist or another provider. Patients are concerned with understanding the total financial impact of their healthcare and should not be expected to navigate complex provider arrangements to obtain this information.

The framework should recognise that different providers play different roles in a patient's care and may have varying levels of visibility over the costs charged by others. Accordingly, IFC obligations should be proportionate to the provider's role in the episode of care.

For planned treatment, the lead clinician, treating specialist or practitioner responsible for coordinating care should have primary responsibility for ensuring patients receive an overall cost estimate for the anticipated episode of care wherever reasonably practicable. This responsibility should include making reasonable efforts to identify and disclose costs associated with other providers commonly involved in the treatment pathway, including hospital fees, anaesthetist fees and assistant surgeon fees – particularly where the lead clinician is choosing the care team rather than the patient.

At the same time, individual providers should remain responsible for disclosing their own fees and charges directly to patients. This shared responsibility model would avoid placing an unreasonable burden on any single provider while ensuring patients receive comprehensive and consistent cost information.

Hospitals, day procedure centres and other healthcare providers should also have direct obligations to disclose their fees, known out-of-pocket costs and any facility charges payable by patients. Healthcare organisations are often in a unique position to provide information about accommodation fees, theatre costs, medical devices and other charges that may materially affect the total cost of treatment. PHA notes that in most cases, the out-of-pocket costs to patients will be nil, as health funds contract with most private hospitals to ensure patients do not pay additional costs (an excess may apply).

The framework should require providers involved in an episode of care to cooperate with one another to support effective cost disclosure. Patients should not be disadvantaged because providers operate independently or because cost information is fragmented across multiple billing entities. Where one provider holds relevant cost information that another provider requires to fulfil their IFC obligations, reasonable cooperation should be expected.

Consideration should also be given to the role of private health insurers. Although insurers are not healthcare providers and should not be primarily responsible for obtaining IFC, they provide members with accessible information about benefit entitlements, policy exclusions, excesses, co-payments and known gap arrangements. This information is critical to helping patients understand their likely out-of-pocket costs, and member funds remain committed to its provision.

Many insurers already provide members with resources such as “Going to Hospital” and “Find a Provider” guidance to help minimise out-of-pocket costs. Wider adoption across other parts of the industry would help support patient IFC.

Certain exemptions could apply in limited circumstances, such as emergency treatment, urgent clinical situations where obtaining detailed financial consent is not reasonably practicable, or where costs cannot reasonably be estimated in advance. However, these exceptions should be narrowly and very specifically defined and should not undermine the general principle that patients are entitled to understand the likely financial implications of their care before treatment proceeds. Most health care provided in the private system is predictable; complication rates for surgery in Australia are very low indeed (approximately 2%),⁸ with much lower rates of complications in private hospitals compared to public hospitals.⁹

Ultimately, IFC obligations should apply across the private healthcare system rather than being confined to a particular profession or provider type. Every provider that contributes to the costs of a patient’s care should have a responsibility to support fee transparency, while lead practitioners should have an overarching obligation to help patients understand the likely total cost of an episode of care. A broad and coordinated approach will be necessary to reduce unexpected medical bills, improve consumer understanding, and strengthen confidence in the private healthcare system.

⁸ Australian Institute of Health and Welfare 2019. *Admitted patient care 2017–18: Australian hospital statistics*. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.

⁹ Ibid. For example, see table 8.6 (onset during care); tables 4.9, 4.10, 4.12, 6.11 (complications) and table 8.9 (falls)

Form and timing of disclosure

Should IFC be provided in writing?

For planned private healthcare, IFC should be provided in writing as the default standard.

Written disclosure is essential to ensuring that patients receive clear, consistent and accessible information about the likely costs of their care. Verbal discussions alone are often insufficient, particularly when patients are receiving complex clinical information, are experiencing stress or anxiety about receiving treatment, or are making decisions about treatment over a relatively short period of time. Written information allows patients to review the details in their own time, discuss the costs with family members, friends and/or carers, seek clarification where necessary, and compare treatment options before making a financial commitment.

A written IFC requirement would also promote consistency and accountability across the healthcare system. It reduces the risk of misunderstandings about what was discussed, provides a clear record of the information disclosed, and helps protect both patients and providers in the event of disputes regarding fees or out-of-pocket costs. Without written documentation, it may be difficult to establish whether adequate financial information was provided and understood prior to treatment.

Written IFC should not be viewed as a substitute for meaningful communication between providers and patients. Rather, it should complement verbal discussions about treatment costs. Patients should have the opportunity to discuss financial information, ask questions, and seek clarification before consenting to treatment. Written disclosure ensures these discussions are supported by accurate and consistent information that patients can refer to after the consultation.

For planned private treatment, IFC should be provided sufficiently in advance of the procedure or commencement of treatment to allow patients a genuine opportunity to consider the financial implications of their decision. Cost information provided immediately before treatment may satisfy a technical disclosure requirement but does not provide patients with a meaningful opportunity to make informed choices. Patients should receive financial information early enough to consider alternative providers, treatment options, funding arrangements, or whether to proceed with treatment at all.

As a general principle, written IFC should be provided as soon as reasonably practicable after treatment is recommended and preferably before the procedure is booked or financial commitments are incurred.

The framework should permit disclosure through a variety of formats, including electronic delivery, provided the information is clear, accessible and capable of being retained by the patient. Email, secure patient portals and other digital methods may improve efficiency and accessibility, particularly where patients need to review information from multiple providers. However, patients should be able to request paper-based information if preferred.

Limited exceptions may be necessary where obtaining written IFC is not reasonably practicable, such as during emergency treatment or where urgent clinical circumstances do not allow sufficient time for formal documentation. Such exceptions should be narrowly

defined and should not diminish the expectation that written cost information be provided whenever possible.

Ultimately, written IFC should form a core component of any national framework. Requiring cost information to be provided in writing would improve transparency, support genuinely informed decision-making, reduce disputes regarding medical fees, and create a clear and consistent standard for both patients and providers across the private healthcare system.

Risks and unintended consequences of IFC reform

Are there key risks or unintended consequences that reforms should seek to avoid?

PHA supports stronger and more consistent IFC requirements. However, as with any regulatory reform, careful implementation will be required to ensure the framework achieves its intended objectives without creating unnecessary burdens or unintended consequences for patients and providers.

The existence of implementation risks should not be used as a reason to avoid reform. Rather, these risks should be addressed through thoughtful policy design, proportionate regulation and clear guidance. The benefits of improved transparency, informed decision-making and consumer protection significantly outweigh the potential challenges associated with implementation.

Excessive administrative burden

One potential risk is that IFC requirements become unnecessarily complex or administratively burdensome for providers operating with limited administrative support.

If compliance obligations are overly prescriptive, providers may spend excessive time completing paperwork rather than discussing costs with patients. The objective of IFC should be to improve transparency and communication, not simply create additional documentation requirements.

This risk can be mitigated through the use of standardised templates, digital tools, nationally consistent forms and clear guidance materials. A streamlined approach would improve compliance while minimising administrative burden.

Confusion between estimates and guaranteed prices

A common concern is that patients may incorrectly interpret cost estimates as fixed or guaranteed prices.

Healthcare costs can legitimately vary due to changes in clinical circumstances, unforeseen complications, additional procedures, or variations in treatment requirements – although these circumstances are rare. A regulatory framework that is perceived as requiring absolute price certainty could create unrealistic expectations and increase disputes when actual costs differ from original estimates.

To address this risk, IFC requirements should clearly distinguish between estimates, indicative cost ranges and confirmed charges. Providers should be required to explain material uncertainties and the factors that may influence final costs. Patients generally understand that healthcare involves some uncertainty, provided that uncertainty is communicated transparently.

Discouraging treatment because estimates may change

There is also a risk that some providers may become reluctant to provide detailed cost information if they are concerned about potential liability when costs subsequently change.

This could have the unintended consequence of discouraging providers from engaging in meaningful cost discussions or encouraging overly conservative estimates that are of limited value to patients.

The framework should therefore focus on whether providers made reasonable efforts to disclose anticipated costs based on the information available at the time. Providers should not be penalised for legitimate and unforeseeable changes in clinical circumstances where they have communicated estimates honestly, highlighted uncertainties and updated patients where practicable.

Defensive provider behaviour

Overly punitive compliance regimes may encourage defensive behaviour, where providers focus on legal compliance rather than genuine patient understanding. For example, providers may rely excessively on lengthy forms, disclaimers or legalistic language in an effort to protect themselves from regulatory action. Such an approach could undermine the purpose of IFC by making financial information harder, rather than easier, for patients to understand.

The framework should therefore emphasise meaningful communication and patient comprehension rather than simply the completion of administrative processes. Effective IFC should be measured by the quality and clarity of information provided, not the volume of paperwork generated.

Duplication of disclosure requirements

Another risk is duplication between existing professional obligations, hospital documentation, insurer communications and any new IFC requirements.

Patients may become overwhelmed if they receive multiple disclosures containing overlapping or inconsistent information from different parties involved in their care. Similarly, providers may face unnecessary compliance costs if they are required to satisfy multiple disclosure regimes that cover substantially the same matters.

A nationally consistent IFC framework should seek to harmonise existing requirements wherever possible. Standardised forms, common terminology and aligned regulatory expectations would reduce duplication while improving clarity for consumers.

Maintaining access to care

Reforms should also avoid creating barriers to timely treatment. IFC requirements should support informed decision-making without delaying urgent care or creating unnecessary obstacles to treatment.

Appropriate exceptions should apply in emergency situations and other circumstances where obtaining detailed financial consent is not reasonably practicable. These exceptions should be narrowly defined but sufficiently flexible to ensure patient care remains the primary consideration.

While stronger IFC requirements may create implementation challenges, these risks are manageable and should not deter reform. Excessive administrative burden, confusion regarding estimates, defensive provider behaviour, duplication of disclosure requirements and

digital exclusion can all be addressed through careful policy design, standardisation, proportionate enforcement and practical implementation support.

The greater risk is maintaining the status quo, where many consumers continue to experience unexpected medical bills, inadequate cost information and limited capacity to make informed decisions about their care. With appropriate safeguards, a nationally consistent IFC framework can improve transparency, strengthen consumer confidence and support a more accountable and patient-centred private healthcare system.

Consequences for non-compliance with IFC requirements

Do you think medical providers should be penalised for not providing IFC?

The main consequences for non-compliance with IFC requirements are borne by patients, who may experience unexpected or unexplained costs. Patients should not be liable for out-of-pocket costs where IFC has not been provided.

Medical providers should be subject to proportionate consequences where they fail to provide adequate IFC, particularly where costs were reasonably foreseeable and patients were not given a meaningful opportunity to understand and consider the financial implications of their care before committing to it.

Evidence cited throughout the consultation paper highlights that the existing framework is failing to consistently deliver the level of fee transparency Australian consumers reasonably expect and deserve.

In almost every other sector of the economy, consumers are provided with clear pricing information before committing to purchase a good or service. Whether booking a flight, engaging a lawyer, hiring a tradesperson, authorising vehicle repairs or purchasing professional services, consumers are generally given sufficient information to understand the likely costs involved and decide whether to proceed. Healthcare should not be held to a lower standard of financial transparency.

Some stakeholders argue the inherent unpredictability of healthcare makes comprehensive financial disclosure difficult. PHA acknowledges that clinical complexity, unforeseen complications and changes to treatment plans can affect the final cost of care. although care delivered in the private sector tends to be more predictable.

Such challenges are not unique to medicine. Many professions operate in circumstances where the full scope of work cannot be known in advance. For example, mechanics routinely provide customers with an estimate based on the information available at the time. Where additional issues are identified during the repair process, the mechanic is expected to contact the customer, explain the revised costs and obtain approval before proceeding with further work. Healthcare providers should be held to a similar standard where practical, although PHA notes this should not extend to waking someone during surgery. Where clinical circumstances change and additional costs become necessary, providers should make reasonable efforts to inform patients, or their substitute decision-maker where appropriate, and obtain further financial consent whenever practicable.

Healthcare should not be held to a lower standard of transparency simply because clinical outcomes can be uncertain.

The current absence of meaningful consequences for failing to provide IFC creates an imbalance in accountability. Patients currently bear most of the burden of navigating complex complaint pathways and often have limited access to practical remedies where IFC is absent, incomplete or inadequate.

A regulatory framework that establishes enforceable obligations and meaningful consequences for non-compliance would strengthen incentives for adherence, improve consistency across the sector, and help restore confidence in the private healthcare system.

The United States has introduced surprise billing legislation with bipartisan support to protect patients from unexpected medical costs arising from inadequate fee disclosure or fragmented billing arrangements. Australia should consider similar consumer protections as part of a strengthened IFC framework.

PHA has urged the Australian Government to introduce similar reforms in its 2022 policy paper [*Combatting Surprise Billing in Australia*](#).¹⁰

Penalties for IFC breaches

Any penalties for IFC breaches should be proportionate and targeted. For example, the framework should distinguish between:

- deliberate or reckless failures to provide IFC, including for self-enrichment
- systemic non-compliance by providers or healthcare practices
- isolated administrative errors, and
- situations where costs genuinely change because of unforeseen clinical circumstances.

Providers should not be penalised for giving reasonable and accurate estimates that subsequently change due to unexpected complications or changes in clinical management. Rather, penalties should apply where providers fail to make reasonable efforts to disclose anticipated costs, likely out-of-pocket expenses, material cost uncertainties, or known costs associated with other providers involved in an episode of care.

PHA recommends:

- Legislation change to ensure consumers not held liable for costs not disclosed beforehand, and
- Civil and criminal penalties be introduced for split billing where the full cost of the service is not disclosed to payers.

No liability for excess costs not disclosed beforehand

For non-emergency admissions, providers should be able to disclose costs beforehand.

PHA recommends legislation be introduced to protect consumers by ensuring consumers are not liable for out-of-pocket costs that have not been disclosed at least seven days in advance of a non-emergency procedure, or two days after booking the procedure in cases where the procedure is booked within the seven-day period. Exceptions for more urgent and emergency care will also be necessary.

Health funds are already required to disclose all fees and excess amounts under existing legislation.

Hospitals will need to provide information about fees through the booking medical practitioner or directly to the consumer. Should hospitals fail to do so, they will still receive either the

¹⁰ Private Healthcare Australia (2022) [*Combatting Surprise Billing in Australia*](#).

amount contracted by the health fund, or if there is no contract with the fund in place, the default benefit.

All medical practitioners involved in the consumer's care will need to disclose fees to the patient for the expected services. This may be coordinated through the admitting doctor, the hospital or individually. Should a doctor fail to provide a written quote prior to service, they will receive any fee contracted under a no-gap arrangement with the health fund, or where no agreement exists, they will receive the MBS Schedule fee. Consumers will not be liable for any additional costs.

Offence to not disclose costs

PHA recommends that legislation be introduced to protect consumers by making it an offence to fail to detail the full cost of a service covered by Medicare or by private health insurance to payers.

One mechanism would be to amend the *Private Health Insurance Act 2007* to introduce an offence if any tax invoice for a service billed to Medicare and/or under a private health insurance arrangement (as defined in schedule one) does not include the full cost of the service, referring to the principles of the *Australian Consumer Law 2010*. An explicit clause may be required to prevent split billing or balance billing.

The legislation should provide for civil and criminal penalties. The Secretary of the Department or their delegate should be able to issue a fine or an official warning for each offence (civil penalties) or have the power to refer to prosecutors for egregious or repeated breaches liable for criminal penalties if proven in a court of law.

Civil penalties offer a more flexible, efficient, and easily achievable mechanism for enforcing compliance than criminal penalties, primarily due to lower standards of proof and streamlined court processes. While criminal prosecutions are designed to punish moral culpability with severe sanctions like imprisonment, civil penalties focus on deterrence and rectifying regulatory misconduct. Allowing the Department to provide warnings and levy fines without criminal conviction is a proportional response.

There should be meaningful consequences where providers deliberately mislead patients, insurers or governments about healthcare costs, including through the use of hidden fees, undisclosed charges or billing practices that circumvent Medicare and private health insurance arrangements. Penalties should be available for serious and/or deliberate misconduct. Such measures would reinforce the principle that fee transparency is a fundamental consumer right rather than a voluntary professional obligation.

Importantly, effective enforcement would support not only patient protection but also fairness for providers who already invest significant time and resources in delivering high-quality IFC. A robust compliance framework ensures providers who adhere to best practice are not competitively disadvantaged by those who rely on opaque billing practices or inadequate cost disclosure.

Preferred regulatory framework for strengthening IFC

Who should be the regulator of such a scheme and why?

PHA supports a regulatory framework led by the Department of Health, Disability and Ageing, supported by existing consumer protection regulators, including the Australian Competition and Consumer Commission (ACCC) where appropriate.

While IFC is often described as a professional obligation, at its core, IFC is a consumer protection issue concerned with transparency, informed decision-making and fair dealing. Accordingly, the regulatory framework should be designed from a consumer rights perspective rather than being treated solely as a matter of professional conduct.

Department of Health leadership

The Department of Health, Disability and Ageing is best placed to oversee a national IFC framework because IFC obligations extend beyond the conduct of individual practitioners and are intrinsically linked with Medicare, private health insurance, hospital funding arrangements and provider participation in Commonwealth-funded programs.

A Department-led model would enable the Government to establish nationally consistent standards applying across the private healthcare system rather than relying on profession-specific requirements. It would also support alignment between IFC requirements and broader healthcare reforms aimed at improving affordability, transparency and consumer confidence.

As previously highlighted, many IFC failures arise from fragmented billing arrangements, poor system design and inconsistent disclosure practices rather than isolated professional misconduct. Addressing these issues requires a regulator capable of driving system-wide change across multiple parts of the healthcare sector.

The Department could also leverage existing compliance mechanisms, accreditation frameworks and funding arrangements to encourage adherence. For example, compliance with IFC obligations could be linked to participation in Medicare, private hospital licensing arrangements, accreditation standards or other government-supported health programs.

Role of the ACCC

The ACCC should have a complementary enforcement role where conduct raises broader consumer protection concerns.

Patients purchasing private healthcare services should receive protections comparable to those available to consumers in other sectors of the economy. In most markets, businesses are expected to provide accurate pricing information and refrain from misleading, deceptive or unfair practices. There is no compelling reason why healthcare providers should be exempt from similar expectations.

The ACCC is already responsible for enforcing consumer protection laws relating to pricing transparency, misleading conduct and unfair business practices. Many of the behaviours that IFC seeks to address, such as undisclosed charges, hidden fees, misleading cost information and surprise billing, closely align with established consumer protection principles.

Where there is evidence of systemic non-compliance, misleading representations regarding costs, or business practices that undermine fee transparency, the ACCC would be well placed

to undertake enforcement action. The potential involvement of the ACCC would also help reinforce that financial transparency in healthcare is not merely an ethical aspiration but an enforceable consumer right.

Why Ahpra should not be the primary regulator

While the Australian Health Practitioner Regulation Agency (Ahpra) and the National Boards have an important role in maintaining professional standards, they should not be the primary regulators of IFC. Ahpra's regulatory framework is principally designed to address patient safety, professional competence and professional conduct. IFC breaches will often involve disclosure failures, billing practices and consumer communication issues rather than clinical performance or patient safety concerns.

There is also a risk that locating IFC exclusively within professional regulation would reinforce the perception that IFC is primarily a professional courtesy rather than a legally enforceable consumer entitlement. Many IFC disputes are likely to be better characterised as consumer protection matters than professional misconduct matters.

Public reporting has highlighted ongoing concerns about Ahpra's complaint backlogs, investigator workloads and delays in regulatory decision-making.¹¹ These issues raise legitimate questions about whether the existing notifications framework has the capacity to absorb a significant new category of consumer complaints relating to IFC.

Ahpra may nonetheless have a role where IFC failures form part of broader concerns regarding professional conduct, repeated disregard for professional obligations, or patterns of behaviour that warrant regulatory attention.

A co-regulatory model

The most effective approach may be a co-regulatory framework that combines:

- The Department of Health, Disability and Ageing as the primary policy owner and compliance regulator
- The ACCC as the principal consumer protection enforcement agency for systemic or serious breaches, and to support transparency and deterrence through annual reporting on IFC compliance and consumer experiences
- Ahpra and the National Boards where IFC failures raise broader professional conduct concerns, and
- The Private Health Insurance Ombudsman (PHIO) may assist with individual consumer complaints and dispute resolution.

This approach recognises that IFC sits at the intersection of healthcare regulation, consumer protection and professional practice. No single regulator is best placed to address all aspects of IFC non-compliance.

PHA believes the Department of Health, Disability and Ageing should be the primary regulator of a national IFC framework. As the portfolio agency responsible for health system policy and

¹¹ See 'Toxic' AHPRA culture and complaints backlog in the spotlight, 19 January 2023, available at: [newsGP](#)

administration, the Department is best positioned to establish consistent national requirements, oversee compliance, and drive system-wide improvements. This role should be supported by the ACCC's existing consumer protection powers to address misleading conduct and serious breaches that undermine consumer trust. A Department-led framework, backed by meaningful consumer protection enforcement, would provide the strongest foundation for improving price transparency, reducing unexpected medical bills and strengthening consumer confidence in Australia's private healthcare system.

Professional regulators and complaints bodies should play complementary roles. Ahpra and the National Boards can respond where IFC failures raise questions about professional standards or practitioner conduct, while the PHIO can provide an accessible avenue for individual complaints and contribute valuable data on emerging consumer issues and patterns of non-compliance.

PHA does not recommend a new regulator as it would be too costly with little additional benefit.

Regulatory and system changes to support single billing

Are there system-level incentives or regulatory reforms that would support implementation?

In addition to the legislative changes recommended above, a range of regulatory and system-level reforms would support greater cost transparency and facilitate the implementation of single billing or coordinated episode-of-care billing models. Several system-level changes could support this objective.

Standardised episode-of-care cost estimates

A nationally consistent IFC framework should require medical specialists to provide patients with a standardised episode-of-care cost estimate wherever reasonably practicable. This estimate should consolidate known costs from participating providers into a single document that clearly identifies:

- total estimated costs by MBS item number
- expected Medicare benefits
- expected private health insurance benefits
- anticipated out-of-pocket expenses
- individual provider fees, and
- areas of cost uncertainty.

A standardised format would make information easier for patients to understand and compare while reducing variation in disclosure practices across providers and jurisdictions.

Improved information sharing between providers

One of the barriers to comprehensive cost disclosure is that providers often operate independently and may not routinely share fee information with one another. Regulatory reforms could require providers participating in planned private treatment to cooperate in providing fee information necessary for IFC purposes.

This would not require providers to guarantee the fees charged by others. Rather, it would create a reasonable obligation to share known costs or indicative fee information where doing so would assist consumers to understand the likely total cost of care.

Digital IFC and billing platforms

Governments, insurers and medical and health practitioners could support the development of interoperable digital platforms that enable providers to generate consolidated cost estimates and share financial information securely with patients.

Digital IFC tools could allow patients to:

- receive cost estimates electronically
- view expected rebates and insurance benefits
- compare estimates from different providers

- track changes to costs where treatment plans evolve, and
- retain a permanent record of financial disclosures.

Digital solutions would reduce administrative burden while improving consistency and accessibility. Digital IFC tools are discussed in further detail below.

Support for single billing models

Consideration should be given to enabling voluntary single billing or bundled payment arrangements for planned episodes of care.

Under such models, a lead provider, healthcare facility or designated billing entity could issue a consolidated invoice that incorporates fees from multiple providers involved in treatment. Patients would receive a clearer understanding of the total cost and would avoid the complexity of multiple separate accounts.

Single billing arrangements should be encouraged where practical, although providers should remain free to maintain separate billing arrangements where necessary. The primary objective should be transparency and simplicity for patients rather than mandating a particular commercial model.

Regulatory incentives and compliance measures

Governments should consider linking compliance with IFC requirements to existing regulatory and funding arrangements. This could include:

- making IFC compliance a condition of participation in certain private health funding arrangements
- incorporating IFC requirements into provider accreditation standards
- establishing reporting and auditing mechanisms
- requiring providers to retain records of IFC disclosures, and
- publishing compliance outcomes to encourage transparency and accountability.

Such measures would create stronger incentives for consistent adoption while supporting consumer confidence in the system.

National consistency

Perhaps the most important reform is the establishment of a nationally consistent IFC framework that applies across jurisdictions, provider types and treatment settings.

The current system relies on a patchwork of professional guidelines, industry initiatives and voluntary practices. A nationally consistent framework would provide clarity regarding responsibilities, disclosure requirements, documentation standards and consumer rights. It would also create a foundation upon which more sophisticated reforms, including coordinated billing and episode-of-care cost disclosure, could be implemented over time.

Supports required to strengthen IFC

What supports would be most important to enable stronger IFC requirements?

Strengthening IFC will require more than new regulatory obligations – there is a cultural issue to be addressed. While a nationally consistent IFC framework is essential, its effectiveness will ultimately depend on the availability of practical supports that enable providers to comply efficiently and help consumers understand and use the information they receive.

The most important supports are provider guidance and standardisation, patient education and empowerment, cultural safety and accessibility measures, and digital enablement. Together, these supports would improve consistency, reduce administrative burden and ensure IFC requirements deliver meaningful benefits to patients.

Provider guidance and standardisation

Clear guidance and standardised processes will be critical to successful implementation.

One of the challenges under the current framework is the variation in expectations across professional bodies, specialties and healthcare settings. Many providers may support the principle of IFC but remain uncertain about exactly what information should be disclosed, when it should be provided, and how compliance should be documented.

A national IFC framework should therefore be supported by:

- standardised IFC templates and forms
- nationally consistent definitions and disclosure requirements
- practical guidance materials and examples
- profession-specific implementation resources where necessary
- training and education programs for providers and practice staff, and
- clear guidance regarding disclosure of episode-of-care costs and costs charged by other providers.

Standardisation would improve consistency for patients while reducing administrative complexity for providers. It would also help ensure that providers across the healthcare system are working to the same minimum expectations.

Importantly, guidance should extend beyond clinicians to include practice managers, administrative staff, hospitals and billing teams, who often play a central role in communicating cost information to patients.

Patient education and empowerment

Patients can only provide meaningful financial consent if they understand both the information provided and their rights within the healthcare system.

Many consumers report uncertainty about healthcare costs, Medicare benefits, private health insurance coverage, gap payments and out-of-pocket expenses. Patients may also feel uncomfortable discussing costs with healthcare providers or may incorrectly assume that recommended treatment will be fully covered.

The Government should therefore invest in consumer education initiatives that:

- explain what IFC is and why it matters
- outline the information patients are entitled to receive
- encourage patients to ask questions about costs before treatment
- explain common healthcare billing arrangements
- improve understanding of Medicare
- encourage consumers to contact their private health insurer if they are unsure about their policy coverage
- provide guidance on comparing treatment options and providers, and
- explain available complaint and dispute resolution pathways.

A well-informed consumer is better equipped to engage in discussions about treatment costs and less likely to experience unexpected financial outcomes. However, consumers – particularly those experiencing health conditions as patients – should not bear responsibility for understanding financial consent.

The IFC framework should also establish clear consumer rights, including the right to receive cost information in writing, the right to ask questions about costs, and the right to make informed choices before proceeding with treatment.

PHA again acknowledges recent improvements to the Medical Costs Finder website and its potential to support consumer understanding of healthcare costs. As the Government continues to enhance the platform, opportunities should be explored to better integrate Medical Costs Finder with IFC processes and digital disclosure tools. Consumers should be able to move seamlessly from general information about fees and out-of-pocket costs to provider-specific cost estimates for their own treatment.

Cultural safety and accessibility

Strong IFC requirements will only be effective if financial information is accessible and understandable for all patients.

Certain groups may face particular barriers to understanding healthcare costs and navigating financial consent processes, including:

- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse backgrounds
- people with disability
- people with low health literacy or financial literacy
- older Australians
- people living in rural and remote communities, and
- vulnerable consumers experiencing social or economic disadvantage.

The IFC framework should therefore be supported by measures that promote cultural safety and accessibility, including:

- information written in plain language
- translated materials and interpreter services
- culturally appropriate communication resources
- accessible formats for people with disability
- flexibility in how information is delivered
- support for carers, families and substitute decision-makers where appropriate, and
- guidance on communicating costs to vulnerable consumers.

Patients cannot provide IFC if they do not understand the information that has been provided. Accessibility should therefore be regarded as a fundamental component of IFC rather than an optional consideration.

Digital enablement

Digital tools have significant potential to improve the consistency, efficiency and accessibility of IFC.

Many of the challenges associated with cost disclosure stem from fragmented information systems, manual administrative processes and the involvement of multiple providers within a single episode of care.

Investment in digital solutions could support:

- generation of standardised IFC documents
- electronic delivery of cost estimates
- consolidated episode-of-care cost estimates
- integration of provider fees, Medicare rebates and private health insurance information
- secure storage of IFC records
- automated updates where treatment plans or costs change, and
- improved communication between providers involved in a patient's care.

Digital platforms could also help patients access and retain information, compare expected costs, and review disclosures at a time and place that suits them.

Again, digital solutions should complement rather than replace traditional communication methods. Some patients will continue to prefer paper-based information or face barriers to using digital technologies. Any digital approach should therefore be designed to accommodate varying levels of digital literacy and access.

The successful implementation of stronger IFC requirements will depend on a combination of regulatory reform and practical support measures. Standardised guidance for providers,

consumer education initiatives, culturally safe and accessible communication, and investment in digital tools are all essential to ensuring IFC is consistently delivered and understood. By supporting both providers and patients, these measures would improve fee transparency, strengthen informed decision-making, and help create a more consumer-centred private healthcare system.

Additional issues and reform considerations

Are there any key issues or considerations missing from this paper?

Conflicts of interest disclosure

The disclosure of material financial interests that may influence referral decisions, treatment settings or recommendations regarding a patient's care should also be included in IFC requirements.

An increasing number of medical practitioners, or their immediate family members, hold commercial interests in hospitals, day facilities, diagnostic services and other healthcare businesses to which they refer patients. While such arrangements may be entirely legitimate and can support investment and innovation within the healthcare sector, they can also create actual, potential or perceived conflicts of interest.

Patients are entitled to understand not only the costs associated with their treatment but also any material financial interests that may be relevant to decisions about where and how that treatment is provided. This information is important because treatment in different settings can result in significantly different costs for patients, private health insurers and taxpayers.

For example, some procedures that are routinely undertaken in hospitals or day facilities may, in appropriate circumstances, be safely performed in consulting rooms or other lower-cost settings. Patients may incur additional out-of-pocket expenses, hospital excesses or other costs where treatment is undertaken in a facility in which the referring practitioner has a financial interest. Without disclosure of that interest, patients may be unaware of circumstances that could reasonably be perceived as influencing the recommendation.

Current professional standards already recognise the importance of transparency in this area. Section 10.13.5 of [*Good Medical Practice: a code of conduct for doctors in Australia*](#) requires medical practitioners to disclose any material financial or commercial interest, including those held by a relative, in a hospital, clinic or other healthcare facility to which they refer patients. However, the existing requirement relies largely on practitioner self-reporting and there is currently no systematic mechanism to verify whether disclosures have occurred or to demonstrate that patients have received and understood this information.

Further, some practitioners receive consideration related to the use of particular medical devices. These considerations may include royalties or other direct payments, support for education or research, or other material benefits. These should be disclosed to patients.

A strengthened IFC framework should formalise and standardise these disclosure requirements. At a minimum, providers should be required to:

- disclose any material financial or commercial interest in a facility, product, service or healthcare business they are providing or to which they are referring a patient
- disclose any relevant financial interests held by immediate family members where existing professional standards require such disclosure
- provide this information in writing before treatment proceeds wherever practicable
- explain the nature of the relationship in plain language

- retain records demonstrating that the disclosure was made, and
- provide patients with an opportunity to ask questions before consenting to treatment.

To support accountability, written declarations should be acknowledged by the patient and retained as part of the IFC process. This would provide evidence that the disclosure occurred and help avoid disputes about whether patients were informed of relevant financial interests.

Importantly, disclosure should not imply wrongdoing. The purpose is not to prohibit practitioners from holding ownership interests or participating in healthcare businesses. Rather, it is to ensure transparency and allow patients to make fully informed decisions about their care. Transparency helps protect both patients and practitioners by reducing the risk of perceived conflicts and strengthening trust in the healthcare system.

The inclusion of conflict-of-interest disclosures within a national IFC framework would align with broader consumer protection principles and reinforce the fundamental objective of IFC: ensuring patients receive all information that a reasonable person would consider relevant when deciding whether, where and how to proceed with treatment.

Conclusion

Private Healthcare Australia strongly supports the introduction of a nationally consistent, enforceable informed financial consent framework that places the interests of patients at its centre.

While informed financial consent is widely recognised as an important principle across the healthcare system, the evidence demonstrates that existing arrangements are not consistently delivering the transparency and certainty that consumers need. Too many Australians continue to face unexpected medical bills, fragmented billing arrangements, unclear fee information and uncertainty about the true cost of treatment. These experiences undermine consumer confidence, impede informed decision-making and can discourage people from accessing necessary care.

A strengthened national framework should establish clear consumer rights and provider obligations, require written and timely disclosure of expected healthcare costs, support disclosure of total episode-of-care costs wherever reasonably practicable, and provide meaningful remedies and consequences where obligations are not met. The framework should also be supported by standardised guidance, digital tools, consumer education and accessible communication to ensure it is effective in practice.

Importantly, IFC should be recognised not merely as a professional obligation but as a fundamental consumer protection measure. Patients should be entitled to the same standards of transparency, fairness and accountability that apply in other sectors of the economy when making significant financial decisions.

PHA believes the Department of Health, Disability and Ageing is best placed to lead this reform through a co-regulatory model supported by the ACCC, Ahpra, the National Boards and existing health complaints mechanisms. Such an approach would provide the necessary balance of system-wide oversight, consumer protection and professional accountability.

The current consultation presents an important opportunity to deliver lasting improvements to fee transparency in private healthcare. By establishing a robust national IFC framework, the Government can reduce surprise billing, strengthen consumer confidence, improve accountability across the sector and ensure Australians are better equipped to make informed decisions about their healthcare.

PHA welcomes the Government's ongoing efforts to improve transparency through initiatives such as Medical Costs Finder. Strengthening informed financial consent requirements represents the next critical step in ensuring consumers receive meaningful, personalised and timely information about the costs of their healthcare.

PHA appreciates the opportunity to provide this submission and looks forward to continuing to work with the Australian Government and other stakeholders to improve transparency, affordability and consumer protections across the private health system.

Further reading

Consumers Health Forum (2026) [Health consumers' experiences and perceptions of healthcare costs Report](#)

Grattan Institute (2025) [Special treatment: Improving Australians' access to specialist care](#)

Mandala Partners (2023) [Restoring Affordable Access to Specialist Care in Australia](#), prepared for Private Healthcare Australia.

Patients Australia and La Trobe University (2025) [Patient Voice: Sharing Australian's perspectives and experiences with general practice and specialist out-of-pocket costs](#)

Private Healthcare Australia (2022) [Combatting surprise billing in Australia](#)

RedBridge (2025), [Experiences with medical specialist and surgeon fees](#), prepared for Private Healthcare Australia.