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Department of Health, Disability and Ageing

FEE TRANSPARENCY IN HEALTH CARE: INFORMED FINANCIAL CONSENT AND SPLIT BILLING PRACTICES

Australian and New Zealand College of Anaesthetists (ANZCA) consultation response

3 August 2026

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About ANZCA

The Australian and New Zealand College of Anaesthetists (ANZCA), including the Faculty of Pain Medicine (FPM), is the professional body responsible for the postgraduate training programs of specialist anaesthetists and specialist pain medicine physicians.

We are one of the largest medical colleges in Australia and New Zealand with more than 10,000 fellows and trainees.

A key role of the college is fostering the highest standards of clinical practice, safety and high-quality patient care in anaesthesia, pain medicine and perioperative medicine. We do this through our robust training programs, rigorous standards, continuous education, mentoring and supervision of junior doctors, advocacy, and research.

Consultation scope

The Department of Health, Disability and Ageing consultation describes the current fee transparency processes, highlights potential issues, and makes suggestions for reform to better support patient access to medical care. The key elements examined include:

- Fee transparency
- Importance of informed financial consent (IFC)
- Structural barriers to cost transparency
- Fragmented regulation and enforcement of IFC
- Split billing practices and their impact in cost transparency.

A total of 19 consultation questions were posed.

ANZCA consultation feedback

Note, ANZCA responses are identified in blue coloured text.

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)

Supporting narrative: medical college.

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 Informed Financial Consent (IFC) should be legally enforceable in Australia?

Yes / No / Unsure

Supporting narrative: Noting that we consider it is appropriate that IFC should be required for elective procedures and for urgent cases where it is reasonable to do so. Sometimes the requirement for urgency or the acute condition of the patient may make this difficult or unreasonable.

6. Do you think medical providers should be penalised for not providing IFC to their patients?

Yes / No / Unsure

Supporting narrative: Only if there are justified complaints made.

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).

Expand function of Professional Services Review

1 (2) 3 4 5 6

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

1 2 (3) 4 5 6

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

1 2 3 4 (5) 6

Establish a new regulator to investigate IFC complaints

1 2 3 4 5 (6)

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

1 2 3 (4) 5 6

Education, guidance and voluntary compliance (no legal change)

(1) 2 3 4 5 6

Supporting narrative: Understanding the objective of the reforms is required:

- If the objective is increased awareness, education and use of IFC, then educational resources are important, noting that education and voluntary compliance should be an integral part of ethical medical practice.
- If the objective is compliance, then Professional Services Review, Ahpra or departmental compliance models make sense. In which case, expansion of Professional Services Review is preferred as this has substantial medical input from practitioners nominated by their respective colleges.
- If the objective is consumer redress, a tribunal, ombudsman or small-claims style model may be more appropriate.

- If the objective is a mix, then a hybrid model may be required, with educational resources rolled out, consumer disputes resolved through one pathway and serious misconduct referred to Ahpra or Professional Services Review.

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)?

Yes, in all cases
Yes, for higher cost or planned care only
No, IFC should remain limited to individual provider fees
Unsure

Supporting narrative: Private hospital billing arrangements are often fragmented, making it unreasonable to place responsibility on a single practitioner who may need to spend considerable time obtaining information about the billing practices of other providers. Practitioners should only be accountable for aspects of billing that are within their control. The proposal also suggests that a "lead clinician" should be the one who puts all of this together. It gives an example of cosmetic surgery as part of this, but the latter is a very narrowly defined field with much of the work being simple from a medical perspective. Translating this to a more complex environment would be a nightmare for anyone trying to coordinate cost estimates and I don't think it should warrant further consideration.

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

All registered health practitioners
Medical practitioners only
Medical practitioners in the private setting
Specific specialties or types of care
Only high cost or discretionary services

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

Expected fees charged by the provider
Likely out of pocket costs
Costs billed by other practitioners
Range of possible costs and uncertainties
Treatment alternatives and cost implications
Timing and format of disclosure
Relevant Medicare Benefits Schedule (MBS) item/rebate
Private health insurance benefit
Other (please specify)

Supporting narrative: Providers should provide information about their fees, any fee ranges, and aspects that may affect the final cost of their specific service. Directing patients to accessing reasonable and readily available sources of information about the broader costs associated with their care is also useful. However, providers do not always have access to all information that influences a patient's final out-of-pocket costs. For example, they may not be aware of all agreements between private hospitals and health insurers, how those arrangements affect the total cost incurred by an individual patient or changed clinical circumstances such as prolonged procedure, intraoperative complexities etc.

11. Should IFC be provided in writing?

Yes always
Only above a certain monetary threshold
Only if requested by the patient
No, verbal discussion sufficient
At the discretion of the provider
Yes but with exceptions (please specify)

Supporting narrative: Ideally IFC should be provided or offered in writing, however there are circumstances where this may not be practical or feasible, such as where a patient faces language barriers, is unable to read, has cognitive impairment, or requires urgent or emergency care. There

are also many last-minute additions to lists, emergent procedures, patients in labour where written IFC is not practicable. In these situations, alternative approaches should be used to ensure patients (or their substitute decision-makers) are appropriately informed and understand the likely costs of care.

12. Do you think existing professional codes of conduct provide sufficient clarity on IFC?

Yes / No / Unsure

Supporting narrative: Existing AMA, Ahpra and peak body codes of conduct do provide clear guidance but at lower levels. Other organisations, including all medical colleges, possibly via CPMC, could have a role as well. Clear IFC has to be part of this.

13. What supports would be most important to enable stronger IFC requirements? (Select up to three)

Clearer guidance for providers regarding their obligations, including standard templates
Clearer guidance for patients in how to participate in discussions about the cost of their care
Guidance to support culturally safe dialogues between patients and providers
Digital systems to support cost disclosure
Other, please specify:

Supporting narrative: There are a range of resources available from various organisations and jurisdictions that could serve as a foundation for nationally consistent guidance and education materials for use by both providers and patients, such as https://avant.org.au/informed-financial-consent-collection and https://asa.org.au/wp-content/uploads/2024/05/ASA_PS04_Informed-Financial-Consent.pdf.

14. Are there key risks or unintended consequences that IFC reforms should seek to avoid? (limit of 2000 characters)

- **Interference with the doctor-patient relationship at the point of care**, particularly in emergency and after-hours settings where treatment decisions often need to be made quickly. If IFC requirements become impractical in these circumstances, clinicians may be less willing to participate in after-hours rosters, potentially creating gaps in service provision, particularly for obstetric care.
- **Consumers often have limited ability to choose their anaesthetist**, as surgeons typically work with a small group of regular anaesthetists. Requiring patients to compare billing information across multiple anaesthetists would be complex and may affect surgical booking timeframes. Many patients may also be unaware that they can request an anaesthetic fee estimate at the time of booking, with only the most health-literate consumers likely to do so.
- **Increased administrative burden on clinicians** may arise if IFC reforms introduce additional obligations such as mandatory education, reporting deadlines, fee publication requirements, or ongoing compliance activities. These requirements may disproportionately affect individual practitioners and small practices, while larger organisations and corporate medical groups may be better positioned to absorb the administrative workload due to greater resourcing and support infrastructure.
- **Additional compliance requirements are likely to increase administrative costs**, with these regulator costs ultimately being passed on to patients and the broader community through higher fees.
- **Providing more information does not necessarily improve transparency** and may, in some cases, result in patients receiving inconsistent or contradictory information from different sources, leading to confusion.

15. What role could digital tools play in supporting IFC? (limit of 2000 characters)

ANZCA supports the use of digital tools to enhance IFC by improving the consistency, accessibility and timeliness of cost information. However, digital tools should support, rather than replace, direct conversations between patients and healthcare providers and care should be taken not to

rely too heavily on digital tools. Patients are already receiving information from multiple sources, including surgeons, hospitals, pathology providers, diagnostic services and other healthcare practitioners so digital solutions should be designed to improve understanding, not simply increase the volume of information provided to patients. In addition, digital approaches may be less accessible for some patients, including those with disabilities, people from non-English-speaking backgrounds, and older Australians.

16. Should providers be required to issue a single bill for all items/services associated with an episode of care?

Yes / No / Unsure

Supporting narrative: A single bill is helpful to patients and arguably more transparent so would be desirable in most circumstances. However, in some circumstances, especially in an evolving clinical situation, separate billing for some items may be inevitable. On the other hand, some of the split-billing practices identified in the paper, such as separate "booking" or "administration" fees, are difficult to justify and should be clearly discouraged. Patients are understandably concerned when they are charged substantial additional fees. Similarly, practices that artificially prolong episodes of care to avoid multiple-servicing rules are rarely supported by clinical need and can create significant inconvenience and additional costs for patients. The paper should make clear that episodes of care must not be structured or manipulated in ways that disadvantage patients financially or undermine the intent of transparent, patient-centred care.

17. Are there any system level incentives or changes in regulation that would support providers to issue a single bill? (limit of 2000 characters)

Any move towards single billing should remain voluntary and proportionate, recognising that in many anaesthesia, pain medicine and perioperative care settings the treating clinicians are independent practitioners who do not control the fees, availability or billing practices of other providers involved in the patient's care. Reforms should therefore focus on enabling coordination and transparency rather than transferring responsibility for third-party fees to individual practitioners.

18. Are there any key issues or considerations missing from this paper? (limit of 2000 characters)

- **Unintended bias and discrimination**: Consumers may consciously or unconsciously discriminate against female clinicians, practitioners with culturally diverse names, internationally trained specialists, First Nations doctors, rural practitioners, doctors with disabilities, and newly qualified consultants, inadvertently influencing patient choice based on factors unrelated to quality of care. Consideration should be given to how IFC reforms may differentially affect these groups and whether any safeguards are required to minimise unintended discriminatory impacts.
- **Robust evaluation of reform impacts**: IFC reforms should be evaluated to ensure they improve patient understanding and decision-making without creating disproportionate administrative burden. This should include monitoring compliance costs, administrative workload, complaint patterns, patient comprehension, and patient outcomes across different specialties, care settings and demographic groups. If reforms place excessive emphasis on documentation and regulatory compliance rather than meaningful communication, practitioners may be incentivised to produce lengthy, technically compliant forms that add administrative burden without improving patient understanding.
- **Recognition of different models of care**: The consultation should better acknowledge the complexity of different clinical practice models. Longitudinal, multidisciplinary care for chronic disease and chronic pain is fundamentally different from a discrete procedural episode, and accurate cost estimates can be considerably more difficult to provide over an evolving patient journey. Reforms should be sufficiently flexible to accommodate varying models of care and avoid imposing disproportionate administrative requirements on practitioners managing complex, ongoing conditions.
- **Limited consideration of multidisciplinary care**: The consultation gives limited attention to multidisciplinary models involving physiotherapists, psychologists, nurses, pharmacists

and other health practitioners. This is particularly relevant in pain medicine and perioperative medicine, where care is increasingly delivered by teams across multiple organisations and funding arrangements. Greater consideration should be given to how IFC requirements will operate when several providers contribute to a patient's care and associated costs.

19. Do you have any additional comments on IFC or options for reform? (limit of 2000 characters)

Australia's health system delivers some of the best health outcomes in the world, but it operates within a complex mix of public and private funding arrangements.

ANZCA supports greater transparency regarding the total cost of medical care, including the government and private health insurance rebates patients can expect to receive. Presenting the full funding picture would help consumers better understand both the cost of their care and how it is funded. Focusing solely on IFC obligations for individual medical practitioners risks overlooking important system-wide factors that contribute to out-of-pocket costs.

MBS rebates and private health insurance benefits have remained largely stagnant for many years, while private health insurance generally does not cover outpatient medical services. Over time, Medicare rebates have failed to keep pace with rising practice costs, resulting in a widening gap between rebates and the actual cost of providing specialist care. Understanding this gap is essential to placing specialist fees in their proper context.

Community concerns about out-of-pocket costs are driven not only by medical fees, but also by the growing disparity between those fees and available government and insurer rebates. At the same time, the public hospital system is currently unable to meet the full demand for healthcare services, with no clear plans for expansion sufficient to address this shortfall.

Addressing these challenges requires a genuine whole-of-system approach that considers the roles of governments, insurers, hospitals and healthcare providers, rather than placing primary accountability on individual clinicians.

Dr Lance Emerson
Chief Executive Officer

ceo@anzca.edu.au