

5 August 2026

Via email: specialistaffordability@health.gov.au

**Catholic Health Australia Submission: Fee Transparency in Health Care: Examining
Informed Financial Consent and Split Billing Practices**

Catholic Health Australia welcomes the opportunity to respond to the consultation paper on informed financial consent and split billing practices.

CHA supports a single definition of informed financial consent established in Commonwealth law and applying across the professions, and supports firm action on split billing. Our submission argues three further points. The design of fee transparency matters as much as the decision to require it, because international evidence indicates that publishing individual prices in markets like this one can raise prices rather than lower them. Disclosure alone will not reduce what patients pay, because part of the growth in out-of-pocket costs may reflect the erosion of Medicare rebates and the way MBS items are billed, and some cost uncertainty is structural and needs to be addressed in the Schedule. And transparency obligations should extend to insurers, whose gap and preferred provider arrangements are frequently the largest single determinant of what a patient pays.

The submission sets out 29 recommendations. CHA would welcome the opportunity to participate in the stakeholder consultations foreshadowed for later in 2026.

If you wish to discuss any aspect of the submission further, please contact me on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,



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Catholic Health Australia

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

August 2026

Catholic Health Australia

www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Background

The Department of Health, Disability and Ageing is consulting on options to strengthen informed financial consent (IFC) and address split billing practices in health care. Informed financial consent, the expectation that patients receive clear information about the likely cost of their care before agreeing to it, is endorsed across the medical profession but is defined differently by different professional bodies, is largely voluntary in practice, and gives patients no enforceable right and little practical remedy when it fails. Split billing refers to practices that fragment the cost of a single episode of care across separate charges, such as administration or booking fees levied alongside bulk-billed services or no-gap arrangements, in ways that obscure the true cost from patients and other payers. The consultation forms part of the Government's broader work on the affordability of specialist medical care, alongside legislation to expand the Medical Costs Finder and foreshadowed reforms to referral pathways and scope of practice. The consultation paper canvasses a range of regulatory responses, from strengthened guidance through to new compliance and enforcement mechanisms, and seeks views on whether informed financial consent should be legally enforceable, to whom obligations should apply, and whether cost disclosure should cover the full episode of care.

Submission summary

CHA's members see the consequences of poor fee transparency every day. Many patients arrive for surgery without a clear picture of what they will owe, discover after treatment that separate providers have billed them separately, and in some cases defer or abandon care because they cannot establish what it will cost. The consultation paper's own data confirms this is not a marginal problem: nearly one in five Australians delayed or did not see a specialist when needed, with cost a cited reason for 8.6 per cent of respondents, and 44 per cent of consumers were unaware of specialist fees before their appointment.¹ Cost opacity also appears to operate as a barrier to private hospital care itself. When patients cannot establish what an admission will cost, some elect to be treated as public patients or defer surgery altogether, and private hospitals see this in their reduced volumes. For a sector already under sustained viability pressure, uncertainty about the medical component of an episode, which hospitals do not set and cannot control, is suppressing demand for the care hospitals provide. Fee transparency reform is therefore not only a consumer protection measure but part of restoring confidence in, and the sustainability of, the private hospital system.

CHA supports reform. Our submission argues that the design of new obligations matters as much as the decision to impose them, and that disclosure alone will not reduce what patients pay.

Three things follow from that. First, the form transparency takes determines whether it lowers costs or raises them. International evidence shows that publishing individual prices in referral-based markets with inelastic demand can push prices up rather than down, and Australian research finds that fees are not associated with better outcomes, so price published without quality information invites patients to read one as a proxy for the other. Second, a material part of the growth in out-of-pocket costs may reflect the erosion of Medicare rebates and the way MBS items are selected and combined in billing, rather than fee-setting behaviour alone. The Commonwealth holds the data to establish which, and the policy response should follow the

¹ Consultation Paper, section 3, citing Australian Bureau of Statistics, Patient Experiences, 2024-25, and Mandala Partners and Private Healthcare Australia, Restoring Affordable Access to Specialist Care in Australia, February 2026.

measurement. Third, some cost uncertainty is structural. Clinical complexity, technology choice, and components of an episode that attract no rebate or a time-based rebate all limit the precision any disclosure standard can require, and they need to be fixed in the Schedule rather than disclosed away.

Two further points concern where obligations should fall. Hospitals already provide detailed written IFC under the NSQHS Standards, and the persistent gaps relate to medical practitioner fees, which hospitals neither set nor control. Insurers, whose gap and preferred provider arrangements are often the largest single determinant of what a patient pays, are not currently required to disclose anything about them. A framework that imposes disclosure on providers alone is incomplete.

Recommendations

CHA makes the following recommendations. They are grouped by theme and discussed in the sections that follow.

A single, enforceable standard

1. Establish a single definition of informed financial consent in Commonwealth law, applying across the health professions, specifying what must be disclosed, when, in what form, and the consequence where it is not.
2. Target reform at the gap that actually exists. Do not duplicate the written IFC obligations hospitals already meet under the NSQHS Standards and the second-tier eligibility rules, and do not make hospitals or lead practitioners liable for fees set by independent practitioners over whom they have no authority.
3. Require, for planned procedures where the final cost depends on clinical findings, a best estimate expressed as a range, a plain statement of what drives the variation, identification of the other providers who may bill, and an obligation to update the estimate where the treatment plan changes materially or to explain the variance promptly afterwards.

Fee transparency and publication

4. Build the Medical Costs Finder on the aggregate Medicare data the Commonwealth already holds: typical fees, medians and ranges by service and region, without depending on voluntary participation by practitioners.
5. Publish fees in context and as distributions. Present every fee alongside the MBS rebate, the typical insurer benefit and the resulting out-of-pocket amount, and as medians with ranges rather than single figures, so that an individual high fee reads as an outlier rather than the going rate.
6. Publish quality information alongside price wherever it exists at the level being published, and work with the Department and the Australian Commission on Safety and Quality in Health Care to establish what can responsibly be published, at what level and with what risk adjustment.
7. Build the Medical Costs Finder into referral workflows, so that the parties with negotiating leverage can act on the information.

8. If mandatory publication of individual practitioners' fees proceeds, legislate a review of movements in the distribution of specialist fees within two years of commencement, to be reported publicly.

Establishing what drives fees

9. Undertake and publish analysis of the relationship, over at least the past decade, between movements in MBS rebates, private health insurance reimbursement including gap scheme benefit levels, and the costs practitioners face in private practice.
10. Establish the realistic range of medical indemnity cost increases by specialty, rather than relying on assertion from any party.
11. Publish the Commonwealth's own quantification of the size and distribution of excessive charging: the spread of fees relative to rebates by specialty and region, the share of services delivered with no gap or a known gap, and the extent to which high charging is concentrated among a minority of practitioners.

Billing and item use

12. Establish a standing program of billing-pattern analysis focused on MBS item selection and combination, using the claims data the Department already holds.
13. Connect that analysis to three existing responses: referral through compliance and PSR pathways where billing is an outlier, structural amendment through the MBS Continuous Review where item combinations produce results the Schedule never intended, and descriptor clarification and profession-led education where variation is legitimate. Publish aggregate findings annually.
14. Include within the program variation in item use between practitioners and between training cohorts for equivalent presentations, and engage the medical colleges formally in that work.
15. Design the analysis to distinguish technology approach where the data permits, so that variation attributable to technology is separated from variation attributable to fee-setting.

Amending the Schedule where uncertainty is structural

16. Determine how the costs of established technologies such as robotic assistance are to be recognised, through the item structure, prostheses and device arrangements, or hospital and insurer contracting, rather than by separate charge to the patient at the point of care.
17. Examine a fixed or banded anaesthetic benefit attaching to a listed procedure, so that a patient can be given a firm figure rather than a range.
18. Examine a benefit for surgical assistance where that assistance is clinically necessary, irrespective of whether the assistant is a medical practitioner or a suitably qualified nurse.

Split billing and payment practices

19. Prohibit expressly the charging of any fee associated with a bulk-billed service beyond the assigned benefit, and require that any fee associated with a service claimed under a no-gap or known-gap arrangement be disclosed to, and reflected in the arrangements with, the relevant insurer.
20. Extend any prohibition on split billing expressly to separately charged technology fees, however they are described.
21. Require a single consolidated estimate before treatment for planned care, require all invoices to identify the episode of care to which they relate, and test the feasibility of consolidated billing through the benchmarking and eClaiming infrastructure that already connects hospitals, practitioners and insurers.
22. Provide that where a service is claimable, a patient is not required to pay more than their disclosed out-of-pocket amount in advance, with the practitioner claiming the Medicare and insurer components directly, and revisit the Department's current consumer guidance accordingly.
23. Examine claim lodgement practices and timeframes, so that patients are not left out of pocket because of provider-side delay.

Insurer obligations

24. Place a corresponding disclosure obligation on insurers, requiring them to publish which hospitals and practitioners are covered under each tier of gap arrangement, the criteria for inclusion and exclusion, and how costs arising from complications or extended stays are treated.

Scope over time

25. State disclosure across the full treatment cycle as a medium-term objective and begin the work, starting with high-cost, protocol-driven pathways. Cancer care is the obvious first candidate.

Enforcement

26. Do not establish a new standalone IFC regulator, and do not rely on education and voluntary compliance alone. Neither extreme will deliver.
27. Enforce through existing Medicare compliance machinery, with a carefully expanded PSR remit for serious or repeated failures.
28. Clarify the application of the Australian Consumer Law, with ACCC guidance confirming that failure to disclose unavoidable fees before a patient commits to treatment can constitute drip pricing or misleading conduct.
29. Legislate that fees not disclosed before treatment are not recoverable, so that undisclosed fees above a properly provided estimate range are simply not payable. This is the single most effective measure available, because it requires no complaint, no regulator and no new institution.

Submission

CHA's overall position on informed financial consent

CHA supports IFC becoming a clear, consistent and enforceable expectation across the health system. The current position, in which IFC is endorsed in principle by every professional body but defined differently by each and enforceable by almost none, serves neither patients nor providers. The consultation paper's mapping of the codes at Table 1.5 makes the case well: a patient cannot reasonably be expected to know that their surgeon, anaesthetist and dermatologist each operate under materially different disclosure expectations.

CHA makes one observation at the outset about where the gap actually sits. Hospitals accredited under the NSQHS Standards are already required, through Advisory AS18/10, to provide written IFC covering the procedure, the item number, the hospital fee, the insurer benefit, estimated co-payments and excesses, a statement on cost variability, identification of other providers who may bill separately, and a signed patient acknowledgement. Declared private hospitals seeking second-tier eligibility face further written IFC requirements under the *Private Health Insurance (Health Insurance Business) Rules 2018*. The hospital component of an episode of care is, in practice, the most transparent component. The persistent gaps identified in consumer research relate overwhelmingly to medical practitioner fees, particularly for specialist consultations and the medical component of procedures, which hospitals neither set nor control. Reform should target that gap. It should not add duplicative obligations to hospitals that already meet detailed accreditation requirements, and it should not make hospitals or lead practitioners liable for fees charged by independent practitioners over whom they have no authority.

CHA therefore supports a single national definition of IFC, established in Commonwealth law, that applies across the professions and settles the questions the paper identifies: what must be disclosed, when, in what format, and with what consequence when it is not. The AMA Guide and the CPMC Framework demonstrate that the profession can already agree on the substance. What is missing is a uniform standard patients can rely on and a remedy when it fails.

Fee transparency and the risk of fee inflation

CHA supports the use of data to improve fee transparency. The Medicare claims data the Commonwealth already holds can show patients and referrers the typical fees, rebates and out-of-pocket costs for a service, presented as medians and ranges, without depending on voluntary participation by practitioners. CHA supports the Medical Costs Finder on that basis. Mandatory publication of individual practitioners' fees, as provided for in the *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026* currently before the Parliament, is a different and considerably stronger instrument. CHA's view is that this step needs much more careful consideration, because the form transparency takes determines whether it lowers costs or raises them. The consultation paper itself acknowledges the risk: that fee transparency tools 'may, in some cases, contribute to upward pressure on fees'.²

The international evidence on this point deserves close attention. The canonical case comes from outside health care. In 1993 the Danish competition authority began publishing firm-level

² Department of Health, Disability and Ageing, Fee Transparency in Health Care: Examining Informed Financial Consent and Split Billing Practices, Consultation Paper, 2026, section 8 (Table 2).

transaction prices for ready-mixed concrete, intending to sharpen competition. Within a year, average prices rose by 15 to 20 per cent, as publication allowed firms to observe one another's discounting and reduced the intensity of price competition.³ The mechanism is well understood in the economics literature: when sellers can observe each other's prices in a market where buyers are not price-sensitive, transparency helps sellers coordinate upward more than it helps buyers shop downward. The parallel deserves to be stated plainly: it was the publication of individual firm-level prices, not aggregate market data, that produced this result, and individual-level publication is precisely what the Bill proposes for specialists.

Health care evidence points the same way where the conditions are similar. Following public disclosure of hospital cost information in the United States, hospitals in the lowest quintile of the cost distribution recorded the largest percentage increases, consistent with low-priced providers moving up to match higher-priced peers.^{4,5} Analysis of US disclosure laws finds bidirectional convergence, with high-price hospitals reducing prices while low-price hospitals increase them, and warns that convergence can settle at a narrower band of relatively higher prices.⁶ Evidence from Japan associates disclosure of service prices with increased use of tests and imaging and higher total spending.⁷

The evidence also identifies when transparency does reduce prices, and the answer is instructive for Australia. The New Hampshire state transparency website reduced negotiated prices for surgical procedures by around 5 per cent and radiology by around 9 per cent, but the reductions were driven by insurer and provider negotiation, not by patients shopping on price.⁸ Only about 1 per cent of state residents ever used the website.⁹ Australian research reaches a consistent conclusion: peer-reviewed analysis from the University of Melbourne, examining the Medical Costs Finder alongside the long-run growth of specialist fees, finds that transparency alone will not restrain fees, noting that only around 88 of more than 6,300 eligible specialists had voluntarily published their fees by the end of 2025.¹⁰

None of this argues for abandoning transparency, and CHA does not oppose the objective of the Bill. It argues for taking design seriously. Specialist medicine has features that cut both ways: patients are referred rather than shopping freely, demand is inelastic, provider numbers are

³ Albæk, S., Møllgaard, P. and Overgaard, P.B. (1997), Government-Assisted Oligopoly Coordination? A Concrete Case. *The Journal of Industrial Economics*, 45: 429-443. <https://doi.org/10.1111/1467-6451.00057>

⁴ Chen J, Miraldo M. The impact of hospital price and quality transparency tools on healthcare spending: a systematic review. *Health Econ Rev.* 2022 Dec 14;12(1):62. doi: 10.1186/s13561-022-00409-4. PMID: 36515792; PMCID: PMC9749158.

⁵ Christensen, H. B., Floyd, E., & Maffett, M. (2020). The only prescription is transparency: The effect of charge-price-transparency regulation on healthcare prices. *Management Science*, 66(7), 2861-2882.

⁶ 'To Make Health Care Price Transparency Work, Prioritize Actionable Disclosure and Competition Guardrails', *Health Affairs Forefront*, March 2026.

⁷ Kobayashi D, Goto R, Tsugawa Y. Impact of improved price transparency on patients' demand of healthcare services. *Soc Sci Med.* 2019 Aug;235:112390. doi: 10.1016/j.socscimed.2019.112390. Epub 2019 Jul 9. PMID: 31325901.

⁸ Feng, Y. (2025). Price transparency in healthcare: Bargaining incentives and patient responses. *Journal of Health Economics*, 102, 102998.

⁹ Mehrotra A, Brannen T, Sinaiko AD. Use patterns of a state health care price transparency web site: what do patients shop for? *Inquiry.* 2014 Jan 1;51:0046958014561496. doi: 10.1177/0046958014561496. PMID: 25466414; PMCID: PMC5813657.

¹⁰ Zhang, Y., 'How to make specialists' fees fair? It'll take more than a revamped website', *The Conversation*, March 2026.

constrained in many specialties and regions, and fees are often taken as a proxy for quality. Those are precisely the conditions under which published individual prices can function as a floor and a focal point rather than a ceiling. The design conclusion is that transparency should begin with the aggregate data the Commonwealth already holds, that any move to individual publication must be built to inform patients and referrers without handing practitioners a coordination benchmark, and that transparency must be paired with mechanisms through which someone with negotiating power or regulatory authority actually acts on the information.

Design safeguards CHA recommends

- Lead with aggregate data: publish Medicare-derived typical fees, medians and ranges by service and region as the foundation of the Medical Costs Finder, since this informs patients without creating individual pricing signals for practitioners to match.
- Publish fees in context: always alongside the MBS rebate, typical insurer benefit and the resulting out-of-pocket amount, so the published figure reads as a cost to the patient rather than a market rate for practitioners to match.
- Present distributions rather than single figures: medians with ranges, so an individual high fee is visibly an outlier rather than the going rate.
- Equip referrers, not just patients: the international evidence shows information changes prices when an actor with leverage uses it. GPs making referrals, insurers negotiating gap arrangements and hospitals contracting with practitioners are the Australian analogues, and the Medical Costs Finder should be built into referral workflows.
- Legislate a post-implementation review before individual publication scales: if mandatory publication of individual fees proceeds, it should carry a statutory requirement to evaluate movements in the distribution of specialist fees within two years of commencement and report publicly, so that any convergence toward higher fees is identified early and the settings can be corrected rather than discovered years later.
- Pair transparency with compliance: disclosure of fees should be accompanied by scrutiny of the billing behaviour that generates them, as set out in the next section.
- Publish quality alongside price: fees presented with no indication of outcome invite patients to read price as a proxy for quality, which is the mechanism most likely to push fees upward. Where quality information exists at the level being published, it should be published with the fee.

The last of these safeguards deserves emphasis, because it goes to the mechanism by which transparency raises prices. Where a patient has no information about quality, price becomes the only available signal of it. Peer-reviewed Australian analysis finds that higher fees are not systematically associated with better outcomes or quality, and that fee dispersion is driven by practitioner-level pricing behaviour rather than by patient characteristics, clinical risk or quality.¹¹ Publishing fees without quality information therefore risks entrenching an inference the evidence does not support, and may widen fee variation rather than narrow it as

¹¹ Méndez, S.J., Yong, J., Scott, A., Prang, K-H. and Elshaug, A.G. (2026), 'Price Transparency in Specialist Markets', *Australian Economic Review* 59(1): 119–122. <https://doi.org/10.1111/1467-8462.70051>

practitioners price to perceived quality.¹² CHA members participate in clinical and financial benchmarking and understand the practical difficulty of publishing outcome data responsibly, particularly at the level of the individual practitioner. CHA would support work with the Department and the Australian Commission on Safety and Quality in Health Care to identify what can be published, at what level, and with what risk adjustment, so that fee information is not the only comparative information a patient has.

Understanding what drives fees

Publishing fees in context requires the Department to understand what sits behind a fee. CHA recommends that the Department undertake and publish analysis of the relationship, over at least the past decade, between movements in MBS rebates, private health insurance reimbursement including gap scheme benefit levels, and the costs practitioners face in private practice. Two cost components warrant particular attention: the cost of practice supported through visiting medical officer and service arrangements, and medical indemnity.

The rationale is straightforward. MBS indexation was frozen from 2013–14 and for an extended period to 2017–18, was lifted only progressively to 2020, and has been indexed at low rates since.¹³ Peer-reviewed analysis published this year describes the suppression of rebate indexation between 2014 and 2019 as a fundamental failure of the sustainability principle in the way schedule fees are set.¹⁴ Where rebates have grown more slowly than the cost of delivering a service, some part of the growth in patient out-of-pocket costs represents a transfer of cost from government to patients rather than a change in fee-setting behaviour by practitioners. CHA does not assert what that proportion is. We are asking the Department to establish it, because the appropriate policy response differs depending on the answer.

The analysis is tractable at item level. High-volume procedures such as hip and knee replacement illustrate the point: the recommended fee, the Medicare rebate and the insurer contribution have each moved at markedly different rates over the past twenty years, and that divergence can be traced from published fee schedules and rebate histories. The Department, holding complete claims data, can construct the comparison across the Schedule and by specialty.

On medical indemnity, CHA recommends the Department establish the realistic range of increases by specialty rather than relying on assertion from any party. The available evidence is mixed. Australian Government Actuary analysis indicated that median premiums were broadly stable or declined in nominal terms across most specialties between 2007 and 2019, and fell as a share of practitioner private income.¹⁵ More recent survey evidence reported a median increase of around 20 per cent over the two years to 2022, together with risk surcharges applied

¹² Yong, J., Elshaug, A.G., Méndez, S.J., Prang, K-H. and Scott, A. (2024), 'Sources of specialist physician fee variation: Evidence from Australian health insurance claims data', *Health Policy* 147: 105119. <https://doi.org/10.1016/j.healthpol.2024.105119>

¹³ Australian Medical Association, *Analysis of the Medicare Indexation Freeze*, 2023.

¹⁴ Zhang, Y., Duckett, S. and Kemp, C. (2026), 'Australia's Specialist Fee Failure: Three Principles for a Way Forward', *Australian Economic Review* 59(1): 114–118. <https://doi.org/10.1111/1467-8462.70045>

¹⁵ Australian Government Actuary, *Evaluation of the Stability and Affordability of Medical Indemnity Insurance*, report to the Department of Health, tabled in Parliament November 2020, <https://aga.gov.au/publications/other/evaluation-stability-affordability-medical-indemnity-insurance>

to individual practitioners.¹⁶ The position is contested, which is precisely the reason to establish it.

Analysis of this kind serves the transparency agenda directly. If a material share of out-of-pocket growth is explained by rebate erosion or cost growth, the reform that follows should address rebate adequacy alongside disclosure. If it is not, the case for acting on fee-setting behaviour is stronger and better evidenced. Either way, publishing the analysis would allow this debate to proceed on measurement rather than on competing claims.

How MBS item use drives out-of-pocket costs

A systematic review of item selection and combination

IFC and the Medical Costs Finder make costs visible. Neither addresses how those costs are generated. CHA submits that a significant and under-examined driver of unpredictable and inflated out-of-pocket costs is the way MBS items are selected and combined in billing, and that the Department has both the data and the regulatory machinery to examine it.

The patterns are familiar to hospitals and insurers, and some are acknowledged in the consultation paper itself. They include selection of the highest-rebate item where more than one item could describe a service; co-claiming combinations of items to maximise total billing for a single episode; splitting services across multiple days to circumvent the multiple operation rule; and billing patterns that vary between practitioners performing equivalent procedures. Each of these inflates the amounts from which gaps are calculated, undermines no-gap and known-gap arrangements, and makes it genuinely difficult for any party, including the practitioner's own rooms, to give a patient a reliable estimate.

CHA recommends the Department establish a standing program of billing-pattern analysis focused on item selection and combination, using the Medicare claims data it already holds. This is not a novel capability. The Department's compliance function already applies data analytics to claiming patterns, the Professional Services Review exists to examine conduct that would be unacceptable to a practitioner's peers, and the MBS Continuous Review, supported by the MBS Review Advisory Committee, was established in 2021 precisely to keep items aligned with contemporary practice.¹⁷ There is also clear precedent for acting on the findings: from 1 November 2017, co-claiming of subsequent attendance items with a broad group of surgical operations was blocked on the recommendation of the MBS Review Taskforce.¹⁸

The value of a standing program is that it connects three responses that currently operate separately. Where analysis identifies outlier billing by individual practitioners, the matter can be referred through existing compliance and PSR pathways. Where it identifies item combinations that are technically compliant but produce results the Schedule never intended, the structural fix (amended descriptors, co-claiming restrictions, combined items) can proceed through the MBS Continuous Review. And where it identifies legitimate variation reflecting ambiguous descriptors or differences in training, the response is clarification and education rather than

¹⁶ Australian Medical Association (NSW), 'Medical indemnity concerns', November 2022, <https://www.amansw.com.au/medical-indemnity-concerns/>, reporting member survey results.

¹⁷ Department of Health, Disability and Ageing, Medicare Benefits Schedule (MBS) Review Advisory Committee (MRAC) and the MBS Continuous Review, established 2021.

¹⁸ MBS Online, 'Co-claiming of subsequent attendance items with group T8 surgical operations', factsheet. The restriction commenced 1 November 2017 on the recommendation of the MBS Review Taskforce.

enforcement. Publishing aggregate findings annually would itself discipline behaviour, in the same way that publishing prescribing patterns has done in other parts of the health system.

This recommendation matters for the IFC reform directly. If item selection is opportunistic, no IFC framework can produce reliable estimates, because the estimate depends on which items the practitioner will choose to bill. Cleaning up item use is a precondition for IFC that means something.

Variation in item use linked to training and practice

A related issue the paper does not address is that practitioners performing clinically equivalent work often bill it differently depending on where and when they trained and the conventions of their specialty or sub-specialty. Some of this variation is legitimate clinical difference. Some reflects ambiguous or overlapping item descriptors. Some is revenue-driven. The consequence for patients is that the rebate they receive, and the gap they pay, can depend less on the care they received than on the billing habits of the practitioner they happened to see.

This variation undermines every layer of the transparency agenda. It makes Medical Costs Finder comparisons unreliable, because apparently different fees for 'the same' item may describe different bundles of work, and apparently similar episodes may sit under different items. It complicates IFC, because an estimate is only as stable as the item selection behind it. And it frustrates insurers' gap arrangements, which are structured around items. The billing-pattern analysis program recommended above should therefore examine variation between practitioners and between training cohorts for equivalent presentations, with the initial response being descriptor clarification and profession-led education, escalating to compliance action only where variation is demonstrably revenue-driven. CHA would support the medical colleges being formally engaged in this work, given billing conventions are substantially transmitted through training.

Why a single figure is often not possible

Clinical complexity and the endometriosis example

Any IFC framework must deal with the reality that for some procedures, the final cost genuinely cannot be known in advance. Endometriosis surgery is the clear example of when this can occur.

The severity and extent of endometriosis are frequently established only at operation. The items ultimately billed, and therefore the rebate, the insurer benefit and the patient's gap, depend on intraoperative findings: whether disease is superficial or deep infiltrating, whether bowel, bladder or ureteric involvement requires additional procedures, and whether additional specialists are drawn into the operation. Two patients with identical referrals can leave hospital with very different accounts, and neither their gynaecologist nor their hospital could have quoted a single accurate figure beforehand. The Commonwealth has itself recognised this complexity in recent MBS changes, introducing items 125 and 126 for gynaecology consultations of 45 minutes or longer for complex conditions including endometriosis,¹⁹ and

¹⁹ MBS Online, 'New long gynaecological consultations', factsheet: items 125 and 126 (with telehealth equivalents 127 and 129) commenced 1 July 2025 for gynaecology consultations of 45 minutes or longer for complex conditions including endometriosis and pelvic pain.

item 55080 for complex gynaecological ultrasound requiring longer scanning time and greater skill than standard pelvic imaging.²⁰

The design implication is that IFC requirements should mandate honest ranges rather than false precision. A rigid single-figure requirement would either mislead patients or, worse, push practitioners to quote at the top of the plausible range to protect themselves, which would itself become a fee escalator. The history here is cautionary: earlier proposals to restructure the main endometriosis surgery items were credibly estimated to increase out-of-pocket costs by around 20 per cent, illustrating how tightly item structure and patient costs are linked in this area.²¹

CHA recommends that a legislated IFC standard require, for planned procedures where cost depends on clinical findings: a best estimate expressed as a range; a plain statement of what drives the variation; identification of the other providers who may bill; and an obligation to update the estimate where the treatment plan changes materially before or during the episode where practicable, or to explain the variance promptly afterwards where it is not. This is the approach the ASA already describes as good practice for anaesthesia, and it is workable.

Advancing technology as a second source of cost variation

Clinical complexity is not the only reason a patient cannot be given a firm figure. Technology choice produces the same effect, and robotic-assisted surgery is the clearest current example. The MBS rebate attaches to the underlying procedure. There is no separate item recognising a robotic approach, so the rebate for a robotic-assisted procedure is the rebate for the listed operation. The costs specific to the technology, including system usage, instrumentation, consumables and in some cases additional imaging, sit outside the rebate. They are met by the hospital, absorbed by the practitioner, or charged to the patient.

The consequence for transparency is significant. Two patients undergoing the same listed procedure can face materially different out-of-pocket costs depending on the technology used, and that difference is invisible in the item claimed. It also weakens comparison through the Medical Costs Finder, because published fees for an item may describe procedures performed by materially different methods with materially different cost structures.

CHA recommends that the billing analysis proposed earlier in this submission be designed to distinguish technology approach where the data permits, so that variation in charges attributable to technology is separated from variation attributable to fee-setting. More directly, the Department should determine how the costs of established technologies are to be recognised. Where robotic assistance is accepted practice for a procedure, its cost should be addressed through the item structure, through prostheses and device arrangements, or through hospital and insurer contracting. It should not be resolved by a separate charge to the patient at the point of care.

Components of an episode that attract no rebate or a variable rebate

²⁰ MBS Online, 'Diagnostic Imaging Services Table: New ultrasound item for complex gynaecological conditions', factsheet: item 55080 commenced 1 November 2025, requiring a minimum of 30 minutes scanning time and recognising the additional skill involved relative to standard pelvic imaging.

²¹ See for example 'Fighting the scourge of endometriosis', The Medical Republic, 2019, reporting specialist estimates that the MBS Review Taskforce's proposed restructure of items 35637 and 35638 would increase out-of-pocket costs for endometriosis surgery by around 20 per cent.

A third structural reason patients cannot be given a firm figure is that parts of an episode attract no Medicare benefit at all, and others attract a benefit that cannot be calculated in advance. Surgical assistance is the clearest example of the first. Where the assistant is a suitably qualified nurse rather than a medical practitioner, no MBS benefit is payable and the patient is liable for the entire fee. Anaesthesia is the clearest example of the second. Anaesthetic items are time based, so the benefit depends on the duration of the operation and only an estimate is possible beforehand.

Neither is a disclosure failure. Both are features of the Schedule. But they set a hard limit on the precision any IFC requirement can achieve, and they fall on components of the episode the patient did not choose and often does not know exist. A patient chooses their surgeon. They rarely choose the anaesthetist and almost never choose the surgical assistant.

CHA recommends the Department address these structurally rather than leaving them to disclosure alone. Two options warrant examination. The first is a fixed or banded anaesthetic benefit attaching to a listed procedure, so that a patient can be given a firm figure rather than a range. The second is a benefit for surgical assistance where that assistance is clinically necessary, irrespective of whether the assistant is a medical practitioner or a suitably qualified nurse. Both would remove residual uncertainty that no disclosure obligation can reach, and both would reduce patient out-of-pocket costs rather than merely disclose them.

Split billing

Administration and booking fees

CHA supports strong action on split billing as defined in the paper: practices that fragment the cost of a single episode to obscure it from the patient or another payer. Charging a patient an administration or booking fee alongside a bulk-billed service, or alongside a no-gap or known-gap arrangement, defeats the purpose of those arrangements and transfers cost to patients in a form deliberately designed to escape scrutiny. These charges also erode the value proposition of private health insurance at exactly the moment the sector can least afford it, and they undermine the good-faith arrangements between insurers, hospitals and practitioners that keep gaps down. The reported scale, with 29 per cent of patients charged administration or booking fees and hidden fees and upfront deposits potentially totalling \$20 million, warrants a legislative response rather than reliance on untested consumer law.²²

CHA supports an explicit prohibition on charging any fee associated with a bulk-billed service beyond the assigned benefit, and an explicit requirement that any fee associated with a service claimed under a no-gap or known-gap arrangement be disclosed to, and reflected in the arrangements with, the relevant insurer. All charges associated with an episode should be capable of being seen in one place.

Technology fees

CHA also supports action on separately charged technology fees. Where a practitioner levies a fee of this kind in connection with a service claimed through Medicare or under a gap arrangement, the effect is the same as an administration or booking fee. Cost moves outside the visible billing arrangements, outside the rebate, and outside the data the Commonwealth and insurers rely on to understand what patients actually pay, and the charge is generally not

²² Consultation Paper, section 7.1, citing Mandala Partners and Private Healthcare Australia, Restoring Affordable Access to Specialist Care in Australia, February 2026.

claimable by the patient from either Medicare or their insurer. As set out above, where the underlying technology cost is legitimate it should be recognised in the item structure or in contracting. Charging it separately to the patient masks the cost and increases financial pressure at the point of care. CHA recommends that any prohibition on split billing extend expressly to fees of this kind, however they are described.

A single bill for an episode of care

On the question of mandating a single bill for an episode of care, CHA's position is more qualified. A single consolidated estimate before treatment is achievable and should be required for planned care. A single consolidated invoice across what are legally independent businesses raises real questions of payment flows, liability and timing that the paper does not yet work through. CHA suggests the Department pursue the consolidated estimate first, together with a requirement that all invoices identify the episode of care to which they relate, and test the feasibility of consolidated billing through the benchmarking and eClaiming infrastructure that already connects hospitals, practitioners and insurers.

Payment practices that create avoidable financial pressure

The paper does not address two payment practices that impose avoidable financial pressure on patients. CHA asks that both be considered.

The first is the requirement to pay the full fee before a procedure rather than the disclosed out-of-pocket amount. A patient told their gap will be several hundred dollars may nonetheless be asked to fund the whole account, often several thousand dollars, and then wait to be reimbursed for the Medicare and insurer components. For some patients this is the difference between affordable and unaffordable care, and it falls hardest on those least able to carry the cost. The Department's own guidance to consumers states that a doctor should not charge fees unrelated to treatment but may ask a patient to pay an upfront amount before providing treatment.²³ CHA asks the Department to revisit that position for insured patients receiving in-hospital care, where the Medicare benefit and the insurer benefit are known in advance to be payable.

The second is the sequencing of claiming and reimbursement. A patient who has paid in full generally cannot be reimbursed until the hospital and each treating practitioner has lodged a claim, because the insurer cross-references the components of the episode before paying. The integrity rationale is understandable. The consequence is that the patient carries the full cost for as long as the slowest provider takes to lodge, with no visibility of the delay and no means of resolving it.

CHA recommends that IFC reform address both. First, where a service is claimable, a patient should not be required to pay more than their disclosed out-of-pocket amount in advance, with the practitioner claiming the Medicare and insurer components directly. Second, the Department should examine claim lodgement practices and timeframes, so that patients are not left out of pocket because of provider-side delay. Both are practical measures that would reduce financial harm without requiring any judgement about the level of fees charged.

²³ Department of Health, Disability and Ageing, 'Out of pocket costs', health.gov.au.

Transparency of gap arrangements and preferred provider tiers

The paper considers transparency almost entirely as something practitioners and hospitals owe patients. There is a corresponding gap on the insurer side that the paper does not examine, and CHA asks that it be brought into scope.

Gap arrangements now operate in tiers. Under the standard arrangement the patient pays the gap. No-gap and known-gap schemes allow a practitioner to bill the insurer at an agreed rate above the MBS fee, with the patient contribution removed or capped. A further tier involves insurers contracting selected hospitals and practitioners at rates approaching recommended fees, with no out-of-pocket cost to the patient. The experience of CHA members is that the criteria determining which hospitals and practitioners are eligible for arrangements of this kind are not published, and that a patient cannot establish, before choosing a policy, a hospital or a practitioner, whether their care will fall inside or outside a preferred tier.

This matters for IFC in three ways. First, which tier applies is often the single largest determinant of a patient's out-of-pocket cost, and it is set by the insurer rather than by the practitioner or the hospital. A practitioner can disclose their own participation but cannot explain criteria they have never seen. Second, arrangements of this kind narrow the effective choice of hospital and practitioner while being presented to members as a benefit, and the basis of exclusion is not visible either to the patient or to the excluded facility. Third, the treatment of complications and extended length of stay under these contracts is frequently unclear, which matters because that is precisely where the cost risk sits.

CHA does not oppose arrangements that reduce or remove out-of-pocket costs for patients. We are asking that they be transparent. CHA recommends that any IFC framework place a corresponding obligation on insurers to disclose, in terms a member can act on, which hospitals and practitioners are covered under each tier of arrangement, the criteria for inclusion and exclusion, and how costs arising from complications or extended stays are treated. A framework that requires disclosure from providers but not from the party setting the benefit is incomplete. A patient cannot be given a reliable estimate of their out-of-pocket cost when a material determinant of that cost is disclosed to no one.

Beyond the procedure: disclosure across the treatment cycle

The paper frames disclosure around an episode of care, generally the procedure and the providers involved in delivering it. For many conditions the procedure is one stage of a longer and more expensive sequence. A cancer diagnosis may involve surgery, then radiation oncology, then medical oncology, with repeated imaging and pathology throughout. Each stage generates separate fees, each has different Medicare and insurance treatment, and much of it is delivered out of hospital where no insurer benefit is payable. A patient given an accurate estimate for their surgery can still face substantial and entirely unanticipated costs over the following year.

CHA accepts that disclosure at this level is considerably harder than disclosure for a single procedure, and we do not suggest it should delay the reforms this paper contemplates. We ask instead that the Department state it as a medium-term objective and begin the work, starting with high-cost pathways where the sequence of services is relatively predictable and protocol driven. Cancer care is the obvious candidate. Patients making decisions at diagnosis are deciding about a treatment pathway, not a procedure, and the financial information available to them should eventually reflect that.

Preferred regulatory approach

Of the options presented at Table 2 of the paper, CHA does not consider that any single option is sufficient on its own, and we caution against the two extremes. Voluntary guidance alone has demonstrably not delivered, as the paper's own evidence shows. A new standalone IFC regulator would duplicate existing bodies, take years to establish and add a further door to the confusing array of complaint pathways the independent review of the National Scheme has already criticised.

CHA's preferred approach combines four elements. First, a single legislated definition of IFC in Commonwealth law, so that every subsequent mechanism enforces the same standard. Second, enforcement through existing Medicare compliance machinery and a carefully expanded PSR remit for serious or repeated failures, recognising the limits the paper identifies, including that this reaches only MBS-funded services. Third, clarified application of the Australian Consumer Law, with ACCC guidance confirming that failure to disclose unavoidable fees before a patient commits to treatment can constitute drip pricing or misleading conduct, which extends protection beyond MBS-funded care.

Fourth, and most importantly for patients, a direct remedy that does not depend on any regulator's caseload: legislating the principle already reflected in case law that a practitioner cannot recover fees that were not disclosed before treatment. There is a sequencing point here worth naming. The Parliament is currently legislating visibility, through the publication powers in the Bill, before it has legislated accountability. If the Department is to hold the power to publish what a specialist charges, a patient should equally be able to rely on what they were told before treatment. Courts have already held that where no higher fee was agreed in advance, the MBS scheduled fee may be implied as the reasonable fee payable and amounts above it are irrecoverable.²⁴ Codifying that principle, so that undisclosed fees above a properly provided estimate range are simply not payable, aligns every practitioner's commercial interest with disclosure. It requires no new regulator, no complaint, and no navigation of the pathways the paper correctly describes as complex and inaccessible. It would do more for IFC compliance than any enforcement program, and it would balance the transparency obligations now being placed on the system with a protection that operates for the individual patient.

Quantifying the problem and confidence in the private system

CHA asks the Department to consider one further matter, which concerns how this reform is communicated rather than how it is designed.

The evidence indicates that inadequate disclosure and excessive charging are real problems, but concentrated ones. Private Healthcare Australia, in its own consumer material, describes the issue as involving a small number of specialists who charge inappropriately high fees.²⁵ Public discussion of the issue frequently generalises well beyond that, to specialists as a group and to private care as a whole.

That generalisation has consequences CHA members see in their hospitals. Patients who could be treated privately, promptly and at modest cost decide not to be, elect public treatment, or defer care. Confidence in the value of private health insurance erodes. Neither outcome serves

²⁴ Consultation Paper, section 6.4, citing case law referenced by Avant in which a court implied the MBS scheduled fee as the reasonable fee payable where no higher fee had been agreed before treatment, and dismissed the claim for the balance.

²⁵ Private Healthcare Australia, 'Out-of-Pocket Costs', consumer information.

patients, and neither is consistent with the Government's objectives of sustaining private capacity and relieving pressure on public hospitals.

CHA is not suggesting the problem be understated. This submission recommends firmer regulation than the current framework provides. The point is that the Commonwealth holds the data to establish the size and distribution of the problem: the spread of fees relative to rebates by specialty and region, the share of services delivered with no gap or a known gap, and the extent to which high charging is concentrated among a minority of practitioners. Publishing that analysis alongside the reform would allow the response to be targeted proportionately, give the profession a fair basis on which to respond, and protect confidence in a sector the Government relies on. Reform grounded in published measurement is more durable than reform driven by contested advocacy.

Conclusion

CHA supports the direction of this consultation. Patients are entitled to know what their care will cost before they commit to it, and the current patchwork of voluntary codes and fragmented complaint pathways does not deliver that.

Our submission asks the Department to do six things. Design fee transparency with the international evidence on fee inflation in view, rather than assuming that publication reduces prices. Use the claims data the Commonwealth already holds to establish both how items are billed and what drives fees, so that reform proceeds from measurement rather than from contested claims. Amend the Schedule where cost uncertainty is structural, because no disclosure obligation can reach uncertainty the Schedule itself creates. Prohibit split billing, separately charged technology fees, and requirements to pay more than the disclosed out-of-pocket amount in advance. Extend transparency obligations to insurers, whose gap and preferred provider arrangements often determine what a patient actually pays. And give patients a remedy that operates without a complaint or a regulator, by legislating that undisclosed fees are not recoverable.

Reform on that basis would improve patient decision-making. It would also support the sustainability of the private hospital sector the Government relies on to relieve pressure on public hospitals. CHA and its members would welcome the opportunity to participate in the stakeholder consultations foreshadowed for mid to late 2026, and to contribute member data on billing practices, gap arrangements and IFC delivery in hospital settings.