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

Department of Health, Disability and Ageing
August 2026

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 24,470 physicians and 9,800 trainee physicians, across Australia and Aotearoa New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients, the medical profession and the community.

Contact Claire Celia, Senior Policy & Advocacy Officer, via the RACP Policy and Advocacy unit policy@racp.edu.au.

We acknowledge and pay respect to the Traditional Custodians and Elders – past, present and emerging – of the lands and waters on which RACP members and staff live, learn and work. The RACP acknowledges Māori as tangata whenua and Te Tiriti o Waitangi partners in Aotearoa New Zealand.

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to respond to the Department of Health, Disability and Ageing's (the Department) consultation paper titled *Fee Transparency in Health Care: Examining Informed Financial Consent and Split Billing Practices*.

Informed Financial Consent (IFC) is a fundamental component of good medical practice, requiring medical practitioners to ensure patients understand the costs, rebates, and out-of-pocket expenses associated with their care before proceeding with non-urgent treatment.

While this obligation is well established in the *Medical Board of Australia's (MBA) Good medical practice: a code of conduct for doctors in Australia (2020)*, the Council of Presidents of Medical Colleges' (CPMC) Medical Specialist Professionalism Framework (2026) and professional codes, **consistent implementation across the profession remains a challenge**.

The Department's consultation paper examines the practical challenges with current IFC and split billing practices and invites feedback on six options for reform:

- Option 1 - Expand function of Professional Services Review (PSR)
- Option 2 - Expand the role of the Department of Health, Disability and Ageing compliance mechanisms
- Option 3 - Ahpra and/or health complaints agency enforcement of IFC using National Law Provisions
- Option 4 - Establish a new regulator to investigate IFC complaints
- Option 5 - Expand existing regulators such as the Australian Competition and Consumer Commission (ACCC) to enforce IFC obligations
- Option 6 - Education, guidance and voluntary compliance (no legal change).

Of the six options presented, **the RACP considers Option 6 (education, guidance and voluntary compliance, with no legal change) the most pragmatic approach at this stage**, consistent with the Australian Medical Association's (AMA) Position Statement on IFC (2024). This position reflects **practical issues that should be addressed before further regulatory or enforcement mechanisms are considered:**

- There is a well-recognised gap in medical practitioners' understanding of billing and IFC requirements, often driven by limited training, delegation of billing to administrative staff, and constraints on fee-setting in employed settings.
- The Government's Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026 represents a significant step toward improving cost transparency and should be given time to be implemented and assessed before additional changes are pursued.

The RACP recommends:

- a **stronger focus on nationally consistent education and practical implementation tools** for medical practitioners,
- a **nationally endorsed IFC education program**, and
- **clearer guidance to help patients participate in cost discussions** and access complaint pathways where needed.

Should additional oversight ultimately be considered, the RACP favours clarifying professional expectations through the MBA and health complaints entities over creating new regulatory powers. This could include strengthening professional codes and standards, improving public awareness of existing complaint pathways, and exploring a streamlined 'one front door' approach to reduce consumer confusion across agencies. **Any expanded refund powers for health complaints entities should require peer review.**

While this consultation focuses on fee transparency, the RACP emphasises that **access and affordability of specialist care are shaped by broader, system-level factors extending well beyond fee information alone**. These include the declining real value of MBS rebates relative to the

cost of delivering care, rising practice expenses, workforce shortages and maldistribution, inadequate public outpatient capacity, and limitations in private health insurance design.

Policy settings for informed financial consent

Informed financial consent is a key part of good medical practice. As such, it is included in the *Medical Board of Australia's (MBA) Good medical practice: a code of conduct for doctors in Australia* (Section 4.5), which sets out the principles of good medical practice and the ethical and professional standards expected of all doctors registered to practise medicine in Australia by both their professional peers and the community.

As outlined in the Council of Presidents of Medical Colleges' (CPMC) Medical Specialist Professionalism Framework published earlier this year, **obtaining written informed financial consent before proceeding with non-urgent care that will incur out-of-pocket fees is mandatory and must be retained in the patient record.** Medical practitioners should ensure that the patient has received and understood the following:

- the proposed services described with the provider's fee and MBS item numbers where relevant
- estimated rebates (where applicable) and expected out-of-pocket cost
- likely additional costs from other providers (e.g. anaesthetist, assistant, imaging). Where these cannot be estimated, patients should be informed of where they can obtain this information.
- circumstances that may change costs e.g. complexity, unpredictable outcomes
- payment expectations and timelines
- options if the care is unaffordable.

The RACP has endorsed the AMA's Guide to Informed Financial Consent, which states that a single episode of care or medical service should not be subject to a booking fee or split bill, and that the practice of charging booking fees and split billing is not supported and may breach a medical practitioner's agreement with the private health insurer, including where fees are not linked to an MBS or AMA Fees List item or are part of a single bill.

Where multiple medical practitioners are involved in a patient's care, the treating medical practitioner has a role in facilitating IFC by providing information about the potential fees of other medical practitioners involved in the procedure or treatment where available. However, responsibility for providing accurate information about a medical practitioner's own fees and obtaining IFC for the services they provide remains with each individual medical practitioner. This reflects the practical reality that treating medical practitioners may not have control over, or complete visibility of, the fees charged by other medical practitioners involved in a patient's care.

RACP position on improving IFC

On balance, of the six options for reform outlined in the Department's consultation paper, **the RACP considers Option 6 - Education, guidance and voluntary compliance (no legal change) the most pragmatic at this stage**. This is consistent with the AMA's Position Statement on IFC (2024), which similarly opposes legislating a direct requirement on medical practitioners to obtain IFC, or introducing sanctions for non-compliance, in favour of voluntary implementation and continued improvement of IFC policies and practices.

As digital disclosure tools and cost transparency mechanisms mature (including the Government's proposed transparency measures to be applied to the Medical Costs Finder), there may be greater scope to consider proportionate compliance measures in the future.

The approach of Option 6 aligns with broader principles of patient-centred care by supporting more consistent, transparent and meaningful IFC discussions.

The position reflects several practical issues that should be addressed before the Government considers introducing additional regulatory or enforcement mechanisms:

- There is a **well-recognised gap in medical practitioners' understanding of billing and IFC requirements**.
    - Billing practices are generally not covered in medical training, and many medical practitioners have limited confidence in this area.
    - In practice, responsibility for billing processes is often delegated to practice managers or administrative staff, meaning medical practitioners may have only a limited understanding of their obligations.
    - In addition, some medical specialists work in settings where fees are determined by their employer or organisation rather than by the individual medical practitioner. In these circumstances, medical practitioners may have limited influence over fee-setting, billing processes or the information provided to patients, despite remaining professionally responsible for ensuring IFC. This can make it more challenging for individual medical practitioners to fulfil their obligations without appropriate organisational systems and support.
    - This suggests there is a need to improve understanding of existing obligations before introducing additional compliance measures.
- The RACP considers that the **measures proposed in the Government's *Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026*[1] should be given the opportunity to be implemented and assessed before further regulatory changes relating to IFC are considered**.
    - The Bill represents a significant step towards improving transparency of medical fees and out-of-pocket costs for private health consumers.
    - Evaluating the impact of these reforms will help determine whether additional measures are required and ensure any future changes are targeted, proportionate and address identified gaps. Moving too quickly to introduce further regulatory obligations risks increasing complexity for medical practitioners and health services, particularly where existing systems and responsibilities across patients, medical practitioners and organisations are still evolving.
- There should be a **greater focus on developing clear, nationally consistent education and guidance to support compliance with IFC requirements**.
    - Education should clearly explain medical practitioners' obligations, rather than relying on general awareness of the principles. It should comprise clear guidance for medical practitioners regarding their obligations, guidance to support culturally safe dialogues between patients and medical practitioners, and digital systems to support cost disclosure.
    - The MBA, Ahpra, medical defence organisations and/or health complaints entities are well placed to develop and promote this guidance in consultation with medical colleges, bringing together existing expectations across Good Medical Practice, AMA guidance, medical colleges' codes and relevant professional frameworks (such as the CPMC Framework) into a single, authoritative source that improves consistency and provides greater clarity for medical practitioners.
- **Education should be supported by practical implementation tools made freely available to medical practitioners through the MBA**. These could include:
    - standard IFC disclosure templates
    - step-by-step guidance for common clinical scenarios
    - patient information resources
    - case studies demonstrating good practice
    - examples of common pitfalls and how to avoid them.

[1] This Bill to which the RACP made a submission will allow the publication of information for patients on medical fees charged by medical practitioners (including specialists and general practitioners) and likely out-of-pocket costs for accessing these services in the private healthcare sector on the Medical Costs Finder.

- **A nationally endorsed IFC education program for** medical **practitioners should also be considered**:
    - A standardised training package, jointly developed and endorsed by the Department of Health, the MBA, the AMA and medical colleges, could provide a consistent baseline understanding of IFC obligations across the profession.
    - Making the program eligible for Continuing Professional Development (CPD) would support uptake.
- **Education initiatives should also extend to patients and consumers.**
    - Clearer guidance on how patients and consumers can participate in discussions about the cost of their care is a critical component of this education and should be given particular emphasis, to ensure patients are genuinely equipped to engage in these conversations and understand their right to IFC.
    - This should include clear information about the avenues available to raise concerns or make complaints, including through existing health complaints entities and Ahpra. While Ahpra does not provide financial redress directly, greater patient awareness of these existing pathways would support better use of the current system and help clarify the extent of any unmet need before further regulatory change is considered.
- **Behavioural ('nudge') approaches should also be explored**.
    - The Australian Government has successfully applied behavioural economics to improve Medicare billing compliance.[2] Similar approaches could be considered to encourage good IFC practices, including prompts, reminders and other practical supports embedded within clinical workflows.

Strengthening professional expectations through the MBA and health complaints entities if additional oversight is considered

If additional oversight is deemed necessary, clarifying professional expectations through the MBA and health complaints entities would be preferable to creating new regulatory powers:

- **The existing regulatory environment is already fragmented, with overlapping responsibilities across multiple agencies.** Creating additional regulators would increase complexity, duplication and uncertainty, while introducing organisations that likely lack expertise in the clinical and professional context in which IFC occurs.
- **Strengthening expectations through professional codes or standards** would provide greater clarity without requiring legislative change.
- **Improving public awareness that health complaints entities already manage IFC-related complaints** would support better use of existing pathways, such as negotiated refunds or referrals to professional boards where appropriate.
- **Considering a more streamlined 'one front door' approach to complaints** could reduce confusion for consumers who currently navigate multiple agencies with overlapping or unclear jurisdiction over IFC-related issues, rather than further fragmenting the existing regulatory landscape.
- **Ensuring any expanded powers considered for health complaints entities to order refunds are subject to an appropriate peer review process** would safeguard against decisions being made without adequate clinical or professional input.

[2] See for example: Nationwide audit and feedback to reduce overuse of pathology tests among high-requesting general practitioners in Australia: a factorial, cluster-randomised, controlled trial - The Lancet Primary Care

Addressing broader health system reforms to improve access and affordability of specialist care

While the Department's consultation paper notes that broader health system reform falls outside the scope of this consultation, the RACP considers it important to acknowledge the wider system factors that underpin access and affordability of medical specialist care.

Affordability is shaped by complex, system-level issues that extend beyond the control of individual physicians. The primary drivers of high out-of-pocket costs are complex and much broader than a lack of fee information and include:

- **MBS rebates not having kept pace with inflation and the true cost of delivering care.** The real value of MBS rebates has fallen considerably due to inadequate indexation and, for several years, a freeze. This gap between rebates and practice costs is a fundamental driver of increasing out-of-pocket costs.
- **Rising practice expenses** including wages, rent, utilities, insurance and equipment.
- **Workforce shortages and maldistribution**, which have constrained meaningful patient choice in many specialties and regions. There are significant care deserts because there is no national coordination of specialist training to ensure a pipeline of doctors to where they are needed.
- **Inadequate public outpatient capacity,** meaning patients who cannot afford private care cannot readily access specialist care publicly.
- **Limitations in private health insurance product design**, which means that patients are not adequately protected from out-of-pocket costs.

Meaningful and sustainable improvements to affordability will ultimately require coordinated action across all levels of government. We note that these broader reform issues will be explored further through the House Standing Committee on Health, Aged Care and Disability's inquiry into access to and affordability of medical specialists in Australia. The RACP looks forward to contributing to this inquiry and to the broader discussion with the Department and the Government on improving access to affordable specialist care.

Closing Comment

We thank the Department for the opportunity to contribute to this important consultation and for considering the recommendations outlined in this submission.

The RACP looks forward to working with the Department to progress improvements in fee transparency mechanisms that **support patients to make informed decisions about their care while promoting clear, transparent and effective billing practices for medical practitioners**.

Meaningful and sustainable improvements to specialist access and affordability will require coordinated government and medical sector action across the health care system. The RACP looks forward to contributing to these broader reform discussions, including through the House Standing Committee's inquiry into access to and affordability of medical specialists.

If you require further information or would like to engage with us, please contact Claire Celia, Senior Policy & Advocacy Officer, via the RACP Policy and Advocacy unit policy@racp.edu.au.