AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T I 61 2 6270 5400
F I 61 2 6270 5499
E I ama@ama.com.au
W I www.ama.com.au
39 Brisbane Ave Barton ACT 2600
PO Box 6090 Kingston ACT 2604

SUBMISSION

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AMA submission on fee transparency — additional comments

By email: specialistaffordability@health.gov.au

Introduction

The AMA appreciates the opportunity to contribute to this Department of Health, Disability and Ageing consultation Fee transparency in health care: examining informed financial consent and split billing practices.

As the department is aware, the AMA has long been proactive in stressing the importance of ethical and professional informed financial consent (IFC) practice to members, and in providing both members and patients with educational materials to support such practice. Relevant AMA publications include the:

- AMA Guide to Informed Financial Consent 2024
- AMA position statement on informed financial consent 2024
- AMA position statement on setting medical fees and billing practices 2024.

Survey questions

The AMA's preferred response to each survey question (other than demographic questions 1–4) is highlighted in bold. Additional clarification or comment is provided where necessary.

Informed financial consent

5. Do you think IFC should be legally enforceable in Australia? (Yes/**No/**Unsure)

The AMA considers IFC a sound ethical, professional and business practice and strongly supports the voluntary implementation and continued improvement of IFC policies and practices by medical practitioners. The AMA notes that there are some avenues available to patients to address concerns in cases where inadequate IFC may have been provided, recognizing that these are fragmented.

However, as outlined in the AMA position statement on informed financial consent 2024, occasionally, the course of medical treatment can be uncertain (for example, in the case of complications or emergencies).

Given these practical impediments to obtaining IFC before a medical service is provided in 100 per cent of cases, the AMA believes that significant caution should be taken if the government decides to develop an overarching legislative framework regarding informed financial consent.

We continue to promote an educative approach and would emphasis that any government intervention would need to be proportional and founded on a peer review process, recognising that the delivery of care is complex and at times uncertain. Any process should focus on fairly resolving complaints as opposed to punitive action and must ensure that matters are effectively screened and vexatious or trivial complaints are not allowed to proceed.

6. Do you think medical providers should be penalized for not providing IFC to their patients? (Yes/**No**/Unsure)

A punitive approach to regulating IFC is not supported. Providing informed financial consent is already a clear part of professional responsibility. Education, peer review and a model that encourages the resolution of complaints about IFC is where policy would be better focused. It is also important that any model under consideration focuses on IFC and does not extend to circumstances where a patient is otherwise unhappy or dissatisfied with the service that is provided and any associated costs. Complaints and regulatory mechanisms for these instances are already in existence.

7. Which regulatory approach do you consider most effective for strengthening IFC?

a. Expand function of Professional Services Review
b. Expand the role of the Department of Health, Disability and Ageing compliance mechanisms
c. Ahpra and/or health complaints agency enforcement of IFC using National Law Provisions
d. Establish a new regulator to investigate IFC complaints
e. Expand existing regulators such as the Australian Competition and Consumer Commission (ACCC) to enforce IFC obligations.
f. Education, guidance and voluntary compliance (no legal change)

The AMA believes the most effective approach to IFC is patient education, and education for medical practitioners to support good practices. Cases requiring steps beyond education should involve a peer review process and should focus on complaint resolution, not punitive action. It is important that complainants are required to attempt resolution with the practitioner in the first instance and to be able to demonstrate how they have done this. Given the multitude of regulatory and complaints mechanisms already in place across the country affecting medical practitioners, strong consideration must be given to the impacts of an increasingly complex regulatory/complaints environment on both practitioners and patients.

8. Should IFC require disclosure of the total expected cost of an episode of care, including costs billed separately by other providers (e.g. anaesthetists, pathology, devices)?

a. Yes, in all cases
b. Yes, for higher cost or planned care only

c. **No, IFC should remain limited to individual provider fees**

d. Unsure.

AMA guidance documents on IFC strongly encourage that where practicable, treating (lead) practitioners:

- provide the patient with the names and contact details of other medical practitioners who will be involved in the episode of care
- provide those other medical practitioners with the patient's details in a timely fashion
- ask those other medical practitioners to provide them information about their fees, so that it can be provided to patients as part of the IFC of the treating practitioner.

However, we note that the Medical Board of Australia's Code of Conduct (clause 4.5.3) only requires that a medical practitioner provides the patient with information about his or her own fees and charges.

The AMA would strongly object to any requirement for an individual medical practitioner to be responsible for providing IFC for other medical practitioners that may be involved in an episode of care because this would greatly increase the administrative burden and medico-legal risk of the lead clinician. For this reason, such a requirement would also lead to an increase in the fees of the lead clinician to accommodate those additional administrative and insurance costs.

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

a. **All registered health practitioners**

b. Medical practitioners only

c. Medical practitioners in the private setting

d. Specific specialties or types of care

e. Only high cost or discretionary services

The AMA believes that IFC obligations should apply to all registered health practitioners. Confining IFC obligations to medical practitioners creates asymmetric obligations — where these obligations are applicable to doctors, while dentists, allied health providers and non-medical health or cosmetic providers carry none. Given that provision of IFC is sound professional practice, it should be sound for every registered health profession.

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

a. **Expected fees charged by the provider**

b. Likely out-of-pocket costs

c. Costs billed by other practitioners

d. **Range of possible costs and uncertainties**

e. **Treatment alternatives and cost implications**

f. **Timing and format of disclosure**

g. **Relevant Medicare Benefit item number**/rebate

h. Private health insurance benefits

i. **Other**

Medical practitioners should not be required to provide detailed information on out of pocket costs, because as the department notes in its consultation paper, "accurately estimating gap fees often requires access to detailed insurance information that may not be readily available to providers at the time consent is sought".[i]

Private health insurance benefits are also often unavailable to practitioners at the time of IFC and so detailed information cannot be provided and is limited to information about how patients can seek that information from their insurer.

Medical practitioners should provide the patient with relevant MBS Item numbers for the proposed treatment or procedure to enable the patient to confirm the applicable Medicare rebate and private health insurance benefit that applies under their policy.

With respect to the "Other' category, the AMA's position statement on IFC also requires that members disclose any direct financial interest they have in connection with the location (e.g. hospital) where the service is to be provided, or any other associated services.

11. Should IFC be provided in writing? *(Select all that apply)*
    a. Yes always
    b. Only above a certain monetary threshold
    c. Only if requested by the patient
    d. No, verbal discussion sufficient
    e. At the discretion of the provider
    f. Yes, but with exceptions (please specify)

In its own policies and guides on IFC, the AMA recommends that IFC be provided to, and given by, patients in writing (including through technologies such as email, SMS and apps) prior to the procedure or treatment being performed. This is so there is a record that both doctors and medical practitioners can refer to, and so that patients know in advance what their out-of-pocket costs may be. This guidance relates predominantly to planned procedures or episodes of care.

However, it must also be recognised that any overarching regulatory framework would likely include all medical services, including general practice, in both community and hospital settings. The provision of informed financial consent for consultations and minor procedures in the community is generally verbal and/or communicated through public information (e.g. on practice website). These, and other exceptions would need to be considered more deeply as part of consultation on any proposed regulation.

In the case of emergency procedures or treatment where a patient may be unconscious or otherwise incapable of receiving or understanding the information, it may not be possible to obtain IFC before the service is performed. If possible, it may be appropriate to provide relevant information to a near relative or someone acting in the patient's interests before the service.

12. Do you think existing professional codes of conduct provide sufficient clarity on IFC?
    Yes/no/unsure

The AMA believes that its publications (linked in the introduction to this submission) provide sufficient clarity on both IFC and billing practices for both medical practitioners and patients.

13. What supports would be most important to enable stronger IFC requirements? *(Circle all that apply)*
    a. Clearer guidance for providers regarding their obligations, including standard templates
    b. Clearer guidance for patients in how to participate in discussions about the cost of their care
    c. Guidance to support culturally safe dialogues between patients and providers
    d. Digital systems to support cost disclosure
    e. **Other, please specify**

The AMA already provides guidance on provider obligations, guidance on how to participate in IFC discussions, and templates to assist both our members and their patients.

The Medical Costs Finder website also provides information on informed financial consent for patients, including a link to the AMA Guide to Informed Financial Consent. Soon, it will also provide more information on individual specialist fees, and the rebates provided by individual private health insurers, for the benefits of patients. The AMA has supported these changes.

We also believe the department should ensure they are accompanied by an effective public education campaign to drive patient traffic to the site and improve public understanding. The AMA's view is these, already in train reforms should be implemented and independently evaluated *before* any further regulation is contemplated.

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

Yes.

First, it is imperative that these reforms, and publicity around them does not create a public misapprehension that a lot of doctors are dishonest. Many are already feeling disheartened, distressed (and in some cases, on the verge of leaving the profession) by recent adverse publicity around specialist fees, when we know that there are very few who charge egregious fees that their colleagues would see as unreasonable.

Furthermore, the reality is that out-of-pocket costs are driven by a range of factors that go beyond the doctor's fees and extend to MBS rebates, insurer fee schedules, practice costs and the complexity of care being provided.

Second, it is imperative that any changes do not set up an environment where vexatious or trivial/misconceived complaints are encouraged. This would not help patients and in the long term would likely drive up costs through doctors being unnecessarily involved in disputes. As outlined above, there is already a complex complaints and regulatory environment which patients and doctors must navigate, and adding additional complexity would not be in the interest of patients. There is a risk that complaints relating to satisfaction with a service provided, or the costs involved, rather than the provision of IFC would be inadvertently encouraged, despite other avenues already in existence for these matters.

15. What role could digital tools play in supporting IFC?

As outlined in question 13, our understanding is that doctors are already making use of digital tools to convey and record IFC. The updates to the medical cost finder website should improve IFC for patients. Patient education campaigns (including digital) would be welcomed to accompany this work. The impact of these reforms should be reviewed before additional changes are considered.

Split billing

16. Should providers be required to issue a single bill for all items/services associated with an episode of care? Yes/no/**unsure**

The meaning of this question is unclear as it appears to conflate two separate issues.

The question is posed under the heading 'split billing' — which in the AMA's understanding, and according to the definition provided in the consultation paper[ii], refers to a single provider splitting their bill to obscure the true cost of their service, by (for example) separately charging their patient a booking or administration fee that Medicare and/or private health insurers do not see, or splitting MBS services over multiple days to circumvent the multiple services rule or equivalent.

As far as the AMA is aware, 'split billing' does not include circumstances where a GP may bill one item privately (e.g. a consultation) and bulk bill another to Medicare (e.g. a pregnancy test). If this interpretation of 'split billing' is incorrect, then the AMA wants to hold urgent consultations with the department about its interpretation of the term.

The AMA has always opposed split billing as defined in the consultation paper. This is made clear in all relevant published AMA policies and guides for members and patients (see Q.12).

However, the question asks whether 'providers should be required to issue a single bill for all items/services associated with an episode of care'. This could be taken to mean a bill that includes all items/services provided by the various medical practitioners who may be involved in that episode of care.

The failure to issue such a bill (a bill that includes the costs of all providers involved in an episode of care) is not spilt billing, and as discussed in our response to Q.8, the AMA would strongly reject any requirement for a lead practitioner to provide a bill that includes the costs of all other practitioners who may be involved in the patient's care.

17. Are there any system level incentives or changes in regulation that would support providers to issue a single bill?

Again, it is not clear whether this question relates to the prevention of split billing, as defined in the consultation paper.

If it does, the AMA would suggest the department consider potential reasons why any providers who may be guilty of split billing are engaging in this practice in the first place. In our experience this is often due to practitioners being unaware of complex billing rules. Some are attempting to reduce patient out-of-pocket costs in an environment where MBS rebates and private health insurer rebates (including no and known-gap arrangements) have not been appropriately indexed to the increasing costs of providing care — let alone to the CPI — for many years. This issue is summarised by the AMA in its Gaps that create gaps poster.

Contact

president@ama.com.au

[i] Department of Health, Disability and Ageing (2026). Consultation paper. Fee transparency in health care: examining informed financial consent and split billing practices, p.7.
[ii] Department of Health, Disability and Ageing (2026). Consultation paper. Fee transparency in health care: examining informed financial consent and split billing practices, p.2