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

Cancer Council Australia

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About Cancer Council

Cancer Council is the peak, non-Government cancer control organisation in Australia. As the national body in a federation of eight state and territory member organisations, Cancer Council Australia works to make a lasting impact on cancer outcomes by:

- shaping and influencing policy and practice across the cancer control continuum;
- developing and disseminating evidence-based cancer information;
- convening and collaborating with cross sectorial stakeholders and consumers to set priorities; and;
- speaking as a trusted voice on cancer control in Australia.

Cancer Council acknowledge the traditional custodians of the lands on which we live and work. We pay respect to Aboriginal and Torres Strait Islander Elders past, present and emerging and extend that respect to all other Aboriginal and Torres Strait Islander people.

This submission was authorised by:

Jacinta Reddan
Chief Executive Office
Cancer Council Australia

Submission contact:

cancercontrolpolicy@cancer.org.au

In August 2026, the Australian Government undertook a consultation to better understand how fee transparency is currently experienced by patients and how it could be strengthened. The consultation aimed to inform policy development on informed financial consent and fee transparency, identify priority areas for improvement to enhance patient understanding and confidence, and support the development of future reform options.

Cancer Council Australia responded to the consultation through an online survey. Cancer Council Australia's responses are presented below.

For more information, see the consultation website: https://consultations.health.gov.au/medicare-benefits-and-digital-health-division/fee-transparency-in-health-care-informed-financial/.

Survey Questions

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

- ✓ Yes
- No
- Unsure

IFC requirements should apply regardless of the funding model or health professional involved, not be restricted to Medicare services or medical practitioners.

The IFC landscape currently sits across legislation, professional codes and Standards. Legislative requirements should be accompanied by updates to existing guidance and frameworks to support practical implementation.

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

- ✓ Yes
- No
- Unsure

Clear and independent investigation processes should be established for complaints alleging IFC requirements have not been met before penalties are applied. Penalty options need to be identified and tested ensure these are proportionate to the impact, and as to educate the health professional on best practice.

Which regulatory approach do you consider most effective for strengthening IFC? Please rank the options below from 1 (most preferred) to 6 (least preferred).

- Expand function of Professional Services Review
- Expand the role of the Department of Health, Disability and Ageing compliance mechanisms

- Ahpra and/or health complaints agency enforcement of IFC using National Law Provisions
- Establish a new regulator to investigate IFC complaints
- Expand existing regulators such as the Australian Competition and Consumer Commission (ACCC) to enforce IFC obligations
- Education, guidance and voluntary compliance (no legal change)

Cancer Council supports stronger regulation and education of IFC and believes s a multi-pronged approach is needed. Prioritising one mechanism should not imply others are unnecessary or that a single mechanism will address all needs. The McCabe Centre for Cancer and the Law advises that existing professional standards already require practitioners to obtain IFC, with failures potentially resulting in disciplinary action.[1] New policy measures should strengthen, rather than duplicate, existing frameworks.

Cancer Council supports;

- strengthening practitioner regulation to improve compliance with IFC obligations;
- leveraging existing consumer protections, including under Australian Consumer Law;
- improving education and guidance for providers and consumers; and
- ensuring complaint pathways are clear, accessible and integrated with existing processes to minimise duplication and consumer burden.

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

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

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

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

All health providers should provide IFC for their services, including Ahpra-registered and self-regulated professions.

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

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

- ✓ Other (please specify)

Healthcare providers should provide a comprehensive estimate of the anticipated cost of care, contextualised by the specific treatment plan and individual circumstances. True IFC extends beyond initial costs to include the expected financial implications of the entire episode of care, including options for how treatment is received, potential complications, and additional investigations or treatment.[2] This includes public and private care options, insurance gap arrangements, and costs for telehealth. IFC requires confirmation that the individual sufficiently understands the information provided.

While exact estimates for other providers' fees may not always be possible, patients should be informed of other clinicians who will be involved in their care and how to obtain cost estimates. Providers should seek to identify and communicate foreseeable out-of-pocket costs from providers they routinely refer to minimise unexpected financial burden.

Should IFC be provided in writing?

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

Please specify exceptions to when IFC should be provided in writing

Written cost information should complement, not replace, verbal IFC discussions. Estimates of fees and out-of-pocket costs should be provided in writing, with patients given sufficient opportunity to discuss costs, ask questions and seek clarification before making decisions. Written IFC materials should be accessible to the individual's needs, including Easy Read, or translated.

Written IFC at commencement of care must not replace the ongoing obligation to keep individuals informed of potential costs and changes throughout treatment.

Written IFC should clearly outline services to be provided, associated fees, and Medicare item numbers where available. Where other providers are involved, including where there is often not a direct provide-patient opportunity to interact such as pathology, details of their services, costs, and contact information, or where to get this, should also be provided.

Clear exceptions for care provided in emergency situations should be established.

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

- Yes
- ✓ No
- Unsure

Even with existing professional codes of conduct in place, 'bill shock' is a well recognised issue for Australians affected by cancer.[3, 4] Around 1 in 4 oncologists report low confidence with cost conversations.[5] Health professionals also identify limited guidance, resources and processes as barriers, demonstrating the need for stronger expectations and implementation support.[6, 7]

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

- ✓ Clearer guidance for providers regarding their obligations, including standard templates
- ✓ Clearer guidance for patients in how to participate in discussions about the cost of their care
- Guidance to support culturally safe dialogues between patients and providers
- Digital systems to support cost disclosure
- ✓ Other, please specify: (There is a limit of 1000 characters)

Strengthening IFC requires a coordinated, system-wide approach, with no single initiative being sufficient in isolation. The development of guidelines for healthcare providers and patients should be implemented concurrently, as meaningful IFC depends on both parties having access to the information and resources they need to engage in these discussions. IFC reforms should promote equitable access to care by embedding culturally safe communication, and digital solutions that support accessible, timely, and accurate cost information.

National guidance should clearly establish that responsibility for obtaining IFC rests with the treating healthcare professional, where they have access to all available information from their health service. Discussions about the anticipated costs should be proactively initiated as part of standard care, regardless of whether this is independently raised by the individual.[6]

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

Overall, the benefits of IFC for people with cancer greatly outweigh the potential consequences. However, it is important that unintended negative outcomes are limited as much as possible. This includes ensuring:

- Minimum requirements outlined in IFC regulations are recognised as a baseline and there are opportunities to extend on this. IFC mandates should be supported by guidance outlining optimal approaches to providing IFC and reducing financial burden. This guidance should recognise that IFC is only one component of addressing financial toxicity and should be complemented by appropriate referral pathways to financial support services and broader health system reforms that improve affordability.
- Sanctions that restrict Medicare billing may risk healthcare professionals opting out of the Medicare Benefits Schedule, potentially increasing out-of-pocket costs for individuals or reducing access to health services. IFC reforms must include safeguards to ensure that accountability measures do not shift financial or access burdens onto patients.
- IFC reforms should remain adaptable and responsive to technological advancements that improve the ability of healthcare providers and patients to understand and obtain more detailed estimates to the anticipated costs associated with care.
- IFC is not a fixed process and for people with chronic conditions. Reforms must recognise that IFC is not a one-off event, and that costs may change over time due to changing health conditions, requiring IFC to be revisited.
- IFC is one component of quality care and cost alone should not influence treatment decisions.
- Fee transparency should avoid making a claim or implying that a higher fee indicates a higher quality of service.

What role could digital tools play in supporting IFC?

Digital tools have the potential to support informed financial consent in several ways, including:

- Improving access to resources for both the general public and healthcare professionals.
- Supporting responsive resources that provide up-to-date information on anticipated healthcare costs (such as the Medical Costs Finder).
- Enabling the development of personalised cost estimates using AI and individual factors. However, further exploration is required to ensure these tools are valid, accurate, and implemented in a way that minimises unintended consequences.

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

- ✓ Yes
- No
- Unsure

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

Providers should be encouraged to issue a single, consolidated bill for an episode of care and guidance on discussing the impact on this based on the potential for medical surprises or complications. Individuals should not face unexpected or 'hidden' fees, such as separate administrative or booking charges, that undermine no-gap or known-gap arrangements and reduce billing transparency across Medicare and private health insurance data.

However, for health professionals there are practical challenges associated with providing a single bill. Cancer care is frequently delivered across multiple providers and settings. For health care professionals who work across systems and services, and care for patients whose cancer care is delivered across these different environments, issuing a single bill is currently almost impossible. For example, a person affected by cancer may receive surgery at one facility, systematic therapy in a different hospital, have radiotherapy delivered by a private provider in a third location, and see their oncologist in private rooms in a fourth location. In this context, issuing a single, consolidated bill is currently unlikely to be feasible for many healthcare professionals.

It is unclear where there are circumstances where multiple invoices are clinically appropriate or necessary, and where split-billing arrangements that may be exploiting bulk-billing incentives or private health insurance payment arrangements.

Reform should be accompanied by clearer guidance for healthcare professionals on best-practice billing, that clearly identifies inappropriate billing practices, such as surprise administrative fees. Practical examples of billing approaches for common cancer treatment pathways could support consistent, transparent billing practices across cancer care.

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

IFC cannot be achieved by simply outlining provider fees, it must be contextualised within the broader health system, with education provided where needed.

In addition to the obligations of individual healthcare professionals, health services and providers also have important responsibilities in supporting the effective delivery of IFC. As outlined in the Standard for Informed Financial Consent, health services should establish institutional processes that support healthcare professionals to understand organisational arrangements and fee structures. They should support IFC by providing accessible information and resources for patients under the guidance of the treating healthcare professional, ensure team members are trained to explain fees and respond to

questions, promoting transparency through the collection and monitoring of service-level fee data, and fostering commitment to IFC among all healthcare professionals within the organisation. Reforms to IFC should clearly define obligations of health services, recognising that IFC cannot be achieved through individual healthcare professionals alone.

Do you have any additional comments on IFC or options for reform?

Cancer Council Australia, Breast Cancer Network Australia, Prostate Cancer Foundation of Australia and CanTeen released a voluntary Standard for Informed Financial Consent, identifying practical actions to support consistent IFC implementation. While developed for oncology, its principles are relevant across other health conditions.

References

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