17 August 2026

Specialist Affordability Section
Medical Benefits & Digital Health Division
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Australian Government Department of Health, Disability and Ageing
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Via email: specialistaffordability@health.gov.au

To whom it may concern,

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

Thank you for this opportunity to provide a written submission to the *Fee Transparency in Health Care: Informed Financial Consent and Split Billing Practices* consultation. We would also like to thank the Department for providing us with an extension to the submission close date.

INTRODUCTION

The ASA's Position Statement on Informed Financial Consent (ASA-PS04) outlines the importance of informed financial consent (IFC) and reflects a consensus position that AMA fees represent generally accepted maximums, except where extenuating circumstances apply.

A defining moment in the history of the ASA was its adoption of the Relative Value Guide (RVG) in 1970 and the subsequent adoption of the RVG by the AMA into its List of Medical Services and Fees (Fees List) in 1989. The Relative Value Guide for Anaesthesia was finally adopted into the Medicare Benefits Schedule in November 2001 (Category 3, Group T.10, Subgroups 1–26).

The RVG revolutionised anaesthesia fees and rebates in Australia. Rather than basing anaesthesia fees and rebates on surgical item numbers and using an average anaesthesia time that was often incorrect, the RVG used anaesthesia specific items and actual anaesthesia time so as to tailor the anaesthesia account and rebate precisely to the anaesthesia provided.

The AMA Fees List and the ASA RVG are updated regularly to reflect changes to the Medicare Benefits Schedule and clinical practice as appropriate. They are intended to assist medical practitioners in determining their own fees and billing practices. It is guidance only and doctors remain free to set their own fees.

The ASA notes that the MBS Anaesthesia RVG has gaps - specifically not having MBS item numbers for initiation of anaesthesia for increasingly common procedures. Whilst the ASA is undertaking review of the MBS Anaesthesia RVG to address these issues, it is clear that the current

mechanisms to modernise the MBS, both departmental and political, are mechanism that have failed to maintain a contemporaneous MBS. This is a not insignificant risk and challenge to providing IFC.

INFORMED FINANCIAL CONSENT

1. About the ASA

The ASA was formed in 1934 and is a member-funded organisation dedicated to supporting, representing and educating specialist anaesthetists to ensure the safest possible anaesthesia for the community. We have proudly supported specialist anaesthetists for over 90 years and continue to support members and advance their skills while advocating for the anaesthesia specialty to ensure safe and high-quality patient care for the Australian public.

2. Primary area of practice

ASA members are predominantly specialist anaesthetists. The ASA also represents anaesthetists who practice in pain medicine, and intensive care medicine.

Rural Generalist Anaesthetists (RGA), GP Anaesthetists (GPA) and doctors in general practice or rural medicine delivering anaesthesia services in Australia are also eligible to join the ASA as Associate Members.

3. In which setting do ASA members primarily work in or interact?

ASA members work in both public and private hospitals, day hospitals/day procedure units, rooms (public and private outpatients settings right across Australia. Our most recent Member Survey Report, published in July 2025, indicates that our members work across the following settings:

Public hospital(s)	31%
Private hospital(s)	27%
Mix of both Public and Private hospitals	36%
Locum / Academia & Research / Other	7%

5. Do you think IFC should be legally enforceable in Australia?

The ASA position is that IFC should not be legally enforceable for all situations, for the simple reason that it is not possible in all cases. This is especially the case in the situation of life-threatening medical episodes, after hours, and when the patients MBS or private health insurance rebates are not clear.

The ASA's Position Statement on Informed Financial Consent (ASA-PS04) outlines the importance of informed financial consent (IFC). It describes IFC as any communication (verbal or written) undertaken between a medical practitioner or his/her representative and a patient such that the

patient understands the potential fee for the medical procedure, and the potential rebates for the services from Medicare and/or the patient's private health insurer.

The ASA considers the gold standard for IFC to be a written estimate of the anaesthesia fee (a range is acceptable) together with a reasonable indication of likely out-of-pocket expenses, provided to the patient prior to the day of the procedure along with written acceptance by the patient.

The ASA strongly advises members to adopt best possible IFC practices, with the aim of achieving this gold standard wherever possible. Obtaining IFC from patients is sound, ethical, professional practice. Ultimately, IFC is also good business practice and will result in fewer disputes over accounts, lower debt recovery costs, fewer bad debts, and increased patient satisfaction.

In April this year the ASA published a Summary Report of our 2026 ASA Specialist Fees and Patient Out-of-Pocket Costs survey.

This survey found that, for planned procedures, informed financial consent is typically provided by anaesthetists in advance, most often in writing and managed through anaesthetic practices or billing systems. Most anaesthetists provide clear fee estimates and likely out-of-pocket costs as part of informed financial consent, with the majority including core information such as estimated fees or ranges, expected out-of-pocket expenses, and potential fee variations if clinical circumstances change.

However, this standard will not always be achievable. Obtaining IFC is more difficult for anaesthetists than for most other specialists, particularly for day surgery patients, day-of-surgery admission (DOSA) patients and emergency patients. This is because anaesthetists often have limited or no direct contact with patients until immediately before the procedure, unlike many other specialists who typically see patients in their consulting rooms days or weeks in advance. The anaesthetist is also completely reliant on the proceduralist (for example surgeon or gastroenterologist) to allocate the list to anaesthetists, and the information for the patients booked on the list to be provided to the anaesthetists. Anaesthetists can, at very short notice (hours) be requested to cover lists due to sick leave, or other logistical reasons which have arisen, for example, a list running over time

For **day surgery** and **day-of-surgery admission (DOSA)** patients, the anaesthetist may not receive the final operating list or patient details until shortly before the procedure. As a result, there may be insufficient time to:

- provide a written fee estimate,
- explain likely out-of-pocket costs,
- answer patient questions, and
- obtain written acceptance before the day of treatment.

For **emergency and unplanned admissions**, the challenges are even greater:

- Clinical care takes priority over administrative and financial discussions.
- Patients may be in pain, distressed, medicated, unconscious, or otherwise unable to meaningfully consider financial information.

- The urgency of treatment may make pre-procedure fee discussions impractical or inappropriate. ASA guidance specifically notes that informing patients of fees post-operatively may be necessary in emergencies.

Our Specialist Fees and Patient Out-of-Pocket Costs Report found that anaesthetists frequently describe fee discussions in emergency situations as:

- uncomfortable,
- rushed,
- poorly timed, and
- difficult to conduct meaningfully because patient distress and clinical priorities take precedence.

69% of survey respondents said emergency situations are the biggest barrier to obtaining informed financial consent, reflecting the realities of urgent care.

In unplanned and emergency admissions, informed financial consent is obtained verbally at the time of care. Many anaesthetists report defaulting to no or known gap billing in these situations mostly due to time pressure and patient circumstances. Respondents also frequently report awkwardness in discussing fees with patients in times of distress, and ethical concerns about obtaining consent, leading to waiving and reducing fees.

While every anaesthetist should make all reasonable attempts to provide IFC, the patient's clinical needs must always be the clear and highest priority.

Finally, private health insurers should acknowledge that specialist anaesthetists may charge their usual fee, based on the applicable RVG unit value, including in emergency situations.

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

No. The ASA does not support any blanket penalties where doctors have failed to provide IFC.

In qualifying this however, the ASA has an expectation that an anaesthetist will make reasonable attempts to provide IFC, written or verbal, which may include IFC being provided post anaesthesia in exceptional circumstances.

In circumstances where an anaesthetist routinely fails to provide IFC, the ASA supports a graduated response escalating from education, reflective learning and then formal professional review, where persistent non-compliance is not justified by clinical urgency, patient circumstances, or other reasonable barriers to obtaining consent.

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

The ASA supports **education, guidance and voluntary compliance** (no legal change). We do not support the other approaches that have been outlined in the consultation paper.

f.	Education, guidance and voluntary compliance (no legal change)	**Supported**
a.	Expand function of Professional Services Review	**Not Supported**

b.	Expand the role of the Department of Health, Disability and Ageing compliance Mechanisms	**Not supported**
c.	Ahpra and/or health complaints agency enforcement of IFC using National Law Provisions	**Not supported**
d.	Establish a new regulator to investigate IFC complaints	**Not supported**
e.	Expand existing regulators such as the Australian Competition and Consumer Commission (ACCC) to enforce IFC obligations	**Not supported**

The ASA provides extensive anaesthesia RVG resources and is continuing to build on these resources. Education in the anaesthesia RVG is a core ASA service for trainees, as is ongoing education activity for specialist anaesthetists.

The ASA supports investment in training more medical students and specialist anaesthetists to address the predicted anaesthesia workforce shortage. We also note that a significant barrier to healthcare access is limited public hospital capacity and access to health services funded under the National Health Reform Agreement (NHRA), rather than private specialist fees. The ASA does not support reforms that create or expand bureaucratic structures to strengthen IFC where this would divert limited taxpayer funding from direct patient care and workforce capacity.

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)?

No. IFC should remain limited to individual provider fees.

The anaesthetist will have no visibility and/or awareness of the primary admitting doctors' fees, or of other specialists who may become involved in the clinical care of patients, both in hospital, and out of hospital.

As already noted, the ASA defines IFC as the dialogue (verbal or written) undertaken between a medical practitioner or his/her representative and a patient such that the patient understands the potential fee for the medical procedure, and the potential rebates for the services from Medicare and/or the patient's private health insurer.

9. Who should IFC obligations apply to?

IFC obligations should apply to all registered health practitioners so that patients understand all the potential fee for their health care procedures, and the potential rebates for the services from Medicare and/or the patient's private health insurer.

10. Which information should IFC reasonably require providers to disclose?

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 (see below)

Other

The most important requirement of IFC for patients is their out of pocket costs – the insurance shortfall from their Medicare and/or health insurance rebate, rather than the actual MBS item numbers. For this reason, when a patient will not incur any out-of-pocket expense, the ASA believes the IFC process can be simplified so that the patient is advised that their anaesthesia services will be billed under a No Gap arrangement, with no out-of-pocket cost to them.

MBS item numbers applicable to a clinical episode may change after IFC has been provided to the patient. This can occur where the planned procedure changes, the consented operation is amended, or additional clinically necessary services are required. For this reason, IFC should allow for a reasonable estimate or range of likely costs rather than requiring absolute certainty about the final item numbers at the time consent is obtained.

The final anaesthesia fee includes a time-based component, which is impossible to estimate in advance for all anaesthesia episodes. Anaesthesia time may be affected by factors outside the anaesthetist's control, including surgical complexity, patient-specific factors, equipment issues, and delays in the availability of other healthcare workers, such as radiographers. The final anaesthesia time can only be determined at the end of the episode of care and will be advised in the final anaesthesia account.

Likely out-of-pocket costs can be affected by private health insurer rules, particularly Known Gap limits. This is especially relevant where total anaesthesia time is unexpectedly extended and the insurer's Known Gap arrangements limit the amount that can be billed to the patient.

The ASA does not believe **f. Timing and format of disclosure** is a component of IFC, as opposed having to be disclosed by providers.

11. Should IFC be provided in writing?

The ASA believes Informed Financial Consent is any communication **(verbal or written on paper or transmitted by electronic means)** undertaken between a medical practitioner or his/her representative and a patient such that the patient understands the potential fee for the medical procedure, and the potential rebates for the services from Medicare and/or the patient's private health insurer.

The ASA considers the gold standard for IFC to be a written estimate of the range of anaesthesia fees expected together with a reasonable indication of likely out-of-pocket expenses, provided to the patient prior to the day of the procedure along with written acceptance by the patient.

However, as already noted above, obtaining IFC is more difficult for anaesthetists than for most other specialists, particularly for day surgery patients, day-of-surgery admission (DOSA) patients and emergency patients. This is because anaesthetists often have limited or no direct contact with patients until immediately before the procedure, unlike many other specialists who typically see patients in their consulting rooms days or weeks in advance.

Additionally, patients can be added to operating list at short notice to accommodate patient requests and patient preference, clinical urgency, and replacing patients cancelled due to sick leave, equipment issues etc.

Patients may not all have easy access to emails, be comfortable or familiar with smart device technology, and have medical powers of attorney/guardians.

Finally, where a patient will not incur any out-of-pocket expense, the ASA believes the IFC process can be simplified so that the patient is advised that their anaesthesia services will be billed under a No Gap arrangement, with no out-of-pocket cost to them.

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

Yes. The ASA's Position Statement on Informed Financial Consent (ASA-PS04) provides clear professional guidelines for anaesthetists and IFC.

13. What supports would be most important to enable stronger IFC requirements?

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

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

a) The single biggest risk and unintended consequence from changes to IFC is the cost to meet these changes. Any changes that require any additional costs (staffing, IT systems, time, data, compliance, etc.) are likely to be added to the costs of services to all patients.

b) It can be difficult for anaesthetists in particular to provide IFC to all patients before providing anaesthetic care. The ASA would not want to see the requirement to provide IFC to patients weaponised against doctors when this is not possible.

c) Reforms, such as those proposed for the Medical Costs Finder website (publishing specialist fee data), have the potential to increase fees (i.e. this reform may be inflationary).

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

Digital tools can potentially play an important role in helping patients to better understand IFC and fees involved for their medical and other health care needs.

While the ASA is on record supporting reform initiatives to improve fee transparency, such as those proposed for the Medical Costs Finder website, we are disappointed that this "transparency" will not extend to MBS and private health insurance historical RVG unit value indexation. For more information on this point, please see our response in question 18.

SPLIT BILLING

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

The ASA does not support split billing where its purpose or effect is to obscure the final fee payable by the patient. Fee transparency should be preserved, regardless of whether services are billed under a single account or across multiple accounts.

The ASA notes that the MBS is not contemporaneous and does not always reflect the full range of clinically appropriate anaesthesia services provided in modern practice. There may be services or fee components that are clinically appropriate but not directly replicated in the MBS. The ASA seeks clear guidance from government and private health insurers on how these services should be recognised, how their costs should be allocated, and how they should be disclosed for out-of-pocket cost transparency.

As previously noted, the AMA and ASA Anaesthesia RVGs include additional anaesthesia items not replicated in the MBS Anaesthesia RVG. The ASA supports the use of these item numbers where clinically appropriate. However, where non-MBS RVG items are used, the dollar value should be clearly attributed against a relevant MBS item or episode of care so that the patient, Medicare and private health insurers can understand the total fee, the rebate basis, and any resulting out-of-pocket cost.

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

No response.

MISCELLANEOUS

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

a) The growing gap between cost of providing anaesthesia and MBS and PHI rebates

MBS rebates

The ASA RVG unit value is a suggested maximum monetary value that can be allocated to each ASA RVG unit. This indexed value is a cost-reflective benchmark and is designed to reflect the actual input costs of providing anaesthesia safely (e.g., staffing, indemnity, compliance, technology/equipment, practice overheads). It is a cost-based reference point intended to inform sustainable pricing and contracting.

The MBS RVG unit value on the other hand is a government-set dollar value per RVG unit that is used to calculate the Medicare benefit payable for relevant anaesthesia services. It is a public rebate parameter, reflecting Government indexation policy and budget settings rather than the full cost base of specialist practice.

In November 2001, the ASA RVG unit value was $50.50 per unit. When the MBS RVG unit value was introduced into the MBS for the first time that year, it was set at $17.15 per unit. While healthcare costs have continued to rise since then, both Medicare rebates and private health insurance benefits for anaesthesia services have failed to keep pace.

The Reserve Bank of Australia (RBA) has an Inflation Calculator tool on its website which calculates the change in the cost of purchasing a representative 'basket of goods and services' over a period of time. It is a simple but practical tool that shows how the purchasing power of money in Australia changes over time due to inflation. It does this by re-scaling historical dollar amounts using consumer price inflation, primarily the Australian Bureau of Statistics (ABS) consumer price index (CPI). Had the MBS RVG unit value of **$17.15 in December 2001** been indexed in line with CPI, it would be **$32.87 by December 2025** – well above the current unit value of **$23.10**, illustrating the cumulative impact of sustained under indexation.

It is also important to note that the ABS's consumer price index represents average household spending on a 'basket of goods and services' consisting of 11 major groups including housing, food, transport, education and health. Therefore, if a cost rises faster than household inflation (e.g. medical practice costs, wages, insurance, compliance), the CPI, and therefore the RBA calculator, will understate the real cost growth of that item. The ABS Health group CPI (which includes medical, dental and hospital services) has consistently outpaced headline CPI over long periods, including since 2001.

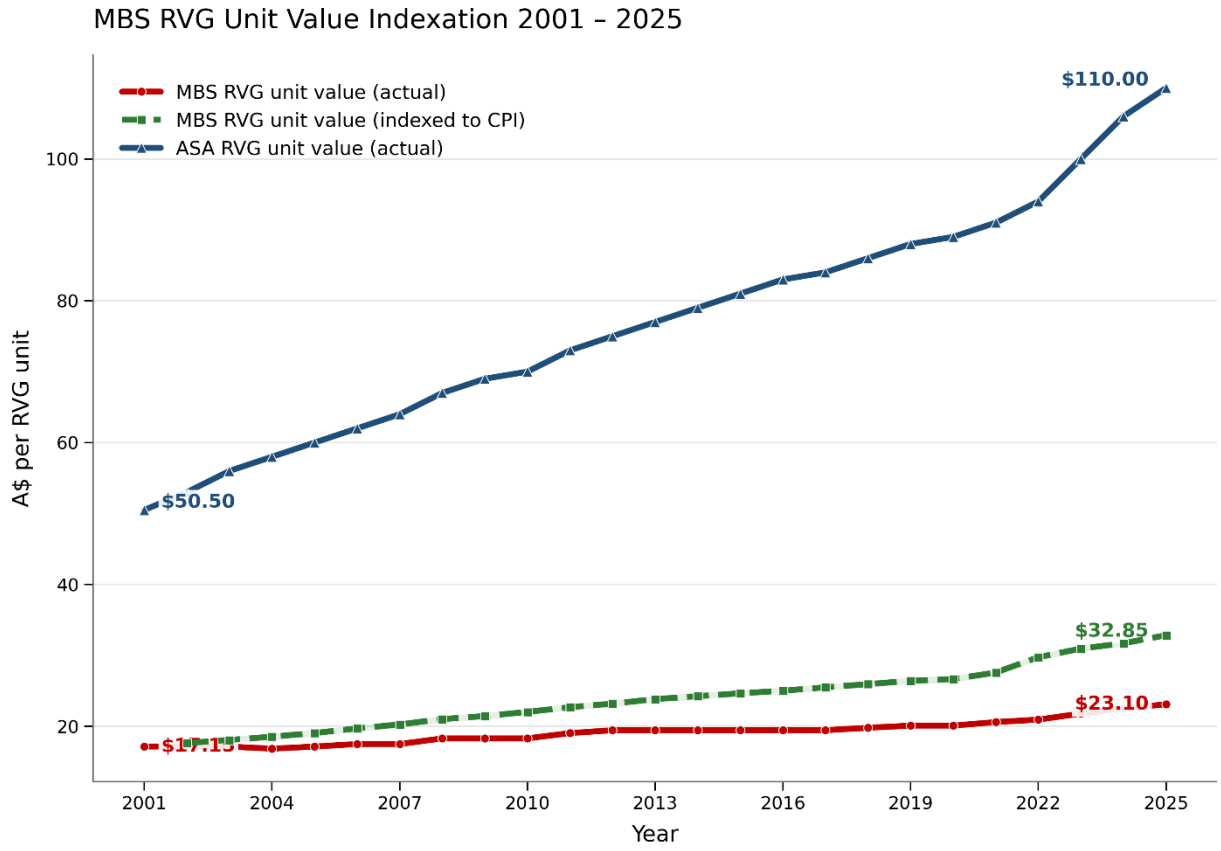
Between **2001 and 2025**, the ASA RVG unit value has increased from **$50.50 to $110 per unit** (an increase of almost 118 per cent). This growth reflects rising practice costs, workforce pressures, equipment upgrades, compliance requirements, and broader inflation across the health sector.

If the ASA RVG unit value of $50.50 in November 2001 increased by CPI alone, in 2025 the value would be $96.54. This is a total change in cost of **91.2 per cent**, over **24 years**, at an average annual inflation rate of **2.7 per cent**. As already noted, over the same period, the MBS RVG unit value has increased far more modestly, from **$17.15** to **$23.10**, an increase of only 35 per cent.

Notably, there was no indexation of MBS rebates between November 2012 and July 2019 (other than a 1.5 per cent indexation to attendance items on 1 July 2018). The current MBS RVG unit value of $23.70 is only 21 per cent of the current ASA RVG unit value which is $110.

When the MBS RVG unit value grows more slowly than practice costs, and private health insurance benefits remain anchored to Medicare settings, the difference is shifted to patients (via increased gap or out-of-pocket costs) and/or absorbed by practices, creating sustainability risks.

The graph below shows actual indexation of the MBS RVG unit value from 2001 to 2025 (red line). It also shows indexation of the MBS RVG unit value if it had been indexed to CPI (green line) and actual indexation of the ASA RVG unit value (blue line) over the same time period.



Private health insurance rebates

Private health insurance rebates have similarly lagged, with funds' rebate schedules falling well short of the ASA RVG unit value. This under indexation has compounded, as private health insurance benefits are tied to the Medicare Schedule Fee, resulting in an even wider gap between rebates and actual costs.

The Health Legislation Amendment (Gap Cover Schemes) Act 2003 enabled private health insurers to introduce no-gap and known-gap schemes to reduce patient out-of-pocket costs. The 'gap' is the difference between what a medical practitioner charges a patient, and what Medicare and the private health insurer pay for that service. Under a no gap arrangement the patient incurs no out-of-pocket cost for the medical service – the medical practitioner accepts the Medicare rebate plus the private health insurer's top up payment as full payment. Under a known gap arrangement, the private health insurer pays a set amount above Medicare, and the medical practitioner may charge above this amount, but the patient's gap (out-of-pocket cost) is known and disclosed in advance (and is capped by the fund). Most major Australian health insurers cap the known gap at $500 per episode of care.

One issue that is often misunderstood is why insurer payments can suddenly drop back to the minimum level required by legislation. Known-gap limits have not been indexed at all since their introduction, despite sustained growth in provider costs over this time. This happens because known-gap payments are voluntary and conditional, not guaranteed. Insurers agree to pay above the Medicare minimum only up to the fixed cap. Once a medical practitioner's fee exceeds that cap, the service no longer qualifies for the known-gap arrangement, and the insurer is only required to pay the statutory minimum – the 25 per cent top-up of the Medicare schedule fee.

While such instances remain relatively uncommon, the ongoing upward pressure on practice costs means that even modest, routine fee increases are increasingly likely to exceed the known-gap cap. When this occurs, costs are shifted back onto patients despite their private health insurance coverage. Compounding this issue, many insurers have moved away from applying known-gap limits on a per-item basis and now apply a single cap across the entire episode of care, encompassing all billed item numbers.

Our survey on Specialist Fees and Patient Out-of-Pocket Costs found that most anaesthetists (84 per cent) participate in no gap, known gap, or a combination of both arrangements with private health insurers. Among those who participate, the majority of private patients are billed under these arrangements, with known gap accounting for a larger share of patients than no gap. The survey also found participation in gap schemes is driven by patient financial considerations, alongside the practical benefits of simplifying billing and reducing the likelihood of disputes or delayed payment. Four in five respondents say they always or sometimes accept the known gap rebates, even when their fee is higher, suggesting they feel compelled to comply with private health insurer rules.

Table 2 demonstrates the scale of the funding gap between the current ASA RVG unit value and MBS and private health insurance rebates.

Table 2: RVG unit values – ASA benchmark vs MBS/DVA and selected private health insurer gap products (2024–2025)

Fund	2024 RVG unit value	2025 RVG unit value
ASA RVG unit value	**$106.00**	**$110.00**
MBS RVG unit value	$22.55	$23.10
Known gap products		
Medibank Private	$37.25	$38.15
AHSA	$37.56	$38.48
St Lukes	$38.80	$39.75
HCF	$37.20	$38.10
Bupa	$37.35	$38.25
NIB GapSure	$43.00	$43.00
No gap products		
HBF Full Cover	$35.85	$36.70
HCF	$38.35	$39.25
Bupa	$38.25	$39.15

On 1 November 2025, the ASA RVG unit value rose from $106 to $110 (+3.8 per cent), reflecting ongoing increases in the real cost of providing anaesthesia services. In contrast, the RVG unit values for Known gap and No gap products for some of the largest private health insurance funds in Australia remain clustered in a range between $37 and $43. Even the highest paid insurer product (NIB GapSure at $45 as of 1 July 2026) remains well below half the ASA RVG unit value of $110. Furthermore, the MBS RVG unit value – currently just $23.70, continues to anchor the system at a low base (around one-fifth of the ASA benchmark) because many insurer products are explicitly or implicitly anchored to the MBS.

As Table 2 above shows, the inadequate indexation of Medicare and private health insurance anaesthesia rebates means they remain structurally misaligned with the real cost of care, entrenching a persistent funding gap that is absorbed by providers and/or shifted to patients and the public system.

The growing disparity between both Medicare and private health insurance rebates and the real costs of providing care creates significant challenges across the entire healthcare system. Patients face the prospect of increased out-of-pocket expenses, even when they hold private health insurance. Healthcare providers, such as specialist anaesthetists, are constantly faced with balancing the provision of quality care with covering rising operational costs.

b) Private health insurance rebate transparency

The ASA is concerned by the lack of transparency and secrecy around incentive payments and/or uplift fees for patients with private insurance arrangements undergoing some procedures at certain private hospitals.

Admission to these facilities is often restricted to low-risk, privately insured patients undergoing a defined set of procedures and managed according to pre-defined clinical pathways. These patients benefit from significant uplift rebates available at these hospitals under No Gap arrangements that reduce or eliminate patient out-of-pocket costs. This is achieved by paying an uplift rebate schedule (i.e. higher patient rebate) for medical services provided to an 'eligible' patient where the doctor agrees to accept the hospital fee schedule and does not charge the patient any out-of-pocket expense.

Patients deemed higher risk, however, are excluded from receiving surgical care at these facilities. Consequently, these patients must seek treatment at fully resourced private hospitals. The absence of uplift rebates means these patients can incur significant out-of-pocket expenses due to the insurance shortfall.

The ASA is concerned that this model potentially challenges the principles of equity and access inherent with community rating. These arrangements provide significantly lower cost health care to selected low-risk patients, whilst maintaining and boosting the health fund rebate paid to specialists. Higher-risk members of the same health insurance fund however are prevented from accessing this type of hospital care due to the hospital's admission eligibility requirements. Furthermore, fund members who do not reside close to one of these hospitals (participating in such arrangements) are also prevented from accessing this type of care.

This model of care currently benefits patients who are eligible to participate in these uplift schemes. The model also allows participating doctors to charge their usual fee with little or no patient out-of-pocket costs. Ultimately however, these arrangements do not address the underlying failure to appropriately index hospital fees, patient rebates and Known Gap limits for the vast majority of patients who are unable to access these incentive payment and/or uplift fees arrangements.

Finally, given the significant variation in private health insurance rebates across hospital settings, private health insurers should be required to disclose to their members, in advance and in plain language, the range of rebates that may apply for their procedure, including how those rebates may differ depending on where the procedure is performed. This would allow patients to understand not only their likely out-of-pocket cost, but also whether the rebate offered by their fund for the same or

comparable service is substantially lower than the rebate available to another member treated in a different hospital under an uplift, no gap or other preferred funding arrangement. If a privately insured patient receives less than half the rebate available to another patient of the same fund for the same item number simply because of hospital location or eligibility criteria, the fund should be required to explain that difference directly to the member. True fee transparency cannot rest solely on doctors disclosing their fees; it must also require health insurers to disclose the rebate rules and selective funding arrangements that materially affect the patient's final out-of-pocket cost.

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

Specialists should always disclose any financial interest they hold in a facility to which they refer patients or at which they participate in the patient's care.

Thank you for this opportunity to make a submission on *Fee Transparency in Health Care: Informed Financial Consent and Split Billing Practices*. Should you require any additional information from the ASA, please contact:

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