Informed financial consent

A collaboration between doctors and patients

Assisting patients to understand their healthcare and its costs

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How a patient's healthcare is funded

Australian healthcare funding is complex.

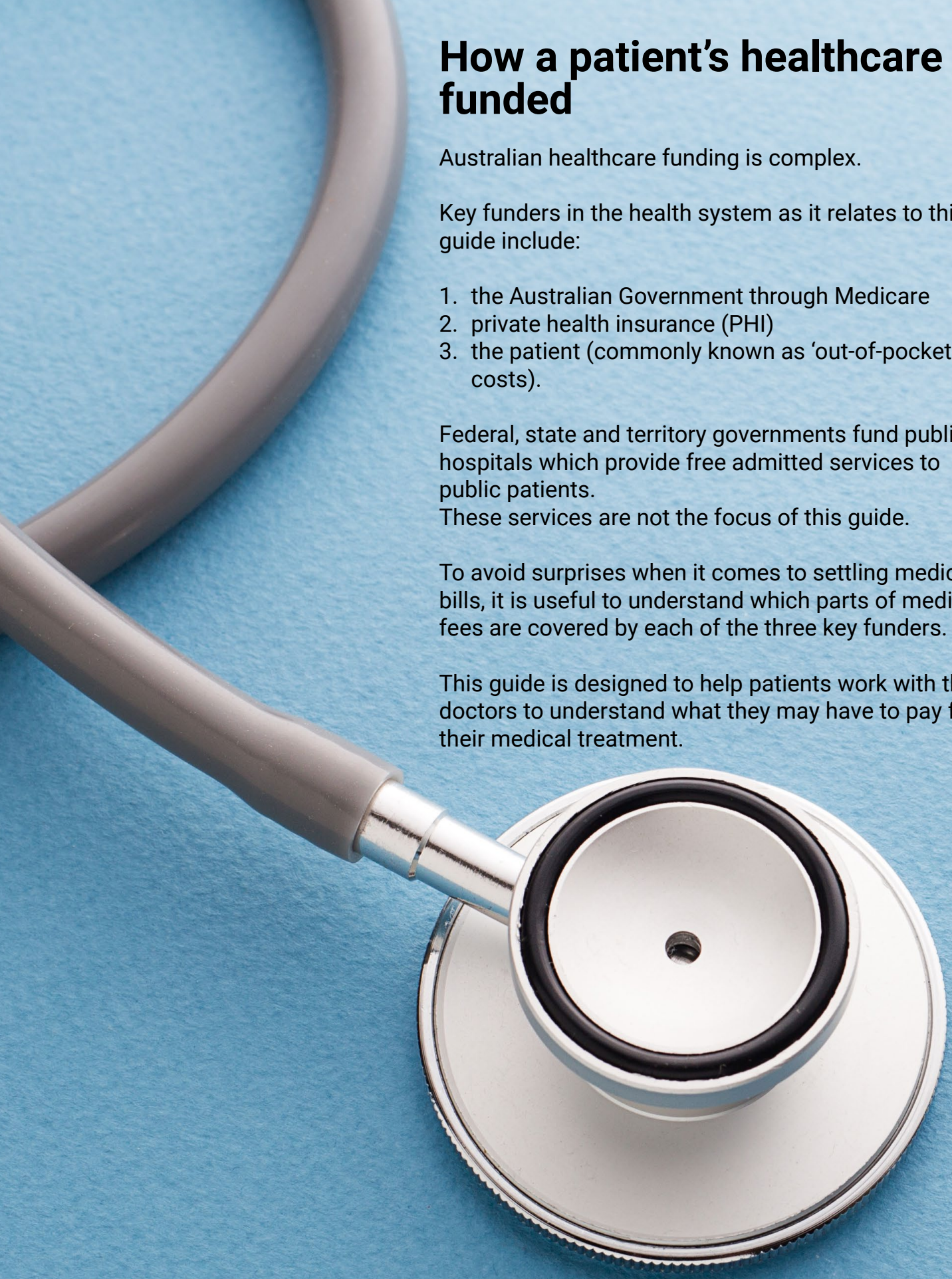
Key funders in the health system as it relates to this guide include:

1. the Australian Government through Medicare
2. private health insurance (PHI)
3. the patient (commonly known as 'out-of-pocket' costs).

Federal, state and territory governments fund public hospitals which provide free admitted services to public patients.
These services are not the focus of this guide.

To avoid surprises when it comes to settling medical bills, it is useful to understand which parts of medical fees are covered by each of the three key funders.

This guide is designed to help patients work with their doctors to understand what they may have to pay for their medical treatment.



Medicare

The Medicare Benefits Schedule (MBS) is a list of the medical services (known as MBS items) for which the Australian Government will pay a Medicare rebate, to provide patients with financial assistance towards the costs of their medical services.

Generally, Medicare pays a percentage of the MBS fee depending on the service provided:

- 100 per cent for consultations provided by a general practitioner (GP)
- 85 per cent for all other services provided by a medical practitioner in the community
- 75 per cent for all services that are provided by a medical practitioner during an episode of hospital treatment when the patient is admitted as a private patient.

The MBS was not designed to cover the full cost of medical services, and over the years, the real value of MBS rebates has fallen considerably, thanks to inadequate (and for several years, nil) indexation against rising costs of living (consumer price index) and even greater increases to the costs of providing medical care. Dental procedures do not attract a Medicare rebate. There is only a small rebate covered for patients if they have extras or general treatment insurance that includes dental cover with their insurer.

Any gap between the MBS rebate and the doctor's fee and any hospital fees ends up being paid by other funders such as private health insurers or the patient.

Private health insurance

Private health insurance covers some, or all, of the cost difference between a doctor's fee and the MBS benefit (rebate) for services delivered to privately insured patients admitted into hospital. This can also include a day hospital. Private health insurance is complex.

The amount covered by the insurer varies by insurer, policy, hospital location, doctor, and sometimes by state and territory.

Each insurer has their own schedule of benefits they pay, but this is not always publicly available or easy for patients to find on their websites.

For hospital treatments, the benefit amount paid to the patient will depend on arrangements in place between the insurer and the doctor, as well as the insurer and the hospital where a patient receives their treatment. However, by law, private health insurers must pay private patients at least 25 per cent of the MBS fee.

There are four aspects of private health insurance for hospital treatment that are commonly misunderstood:

- Health insurers do not cover the costs of consultations or treatment provided by a doctor (general practitioner or non-GP specialist) outside of the in-hospital procedure. This means that initial consults and some follow ups will not be covered by insurance.
- Not all private health insurance policies cover every medical treatment.
- Insurers can change what is covered by a purchased policy, but they must tell you.
- Patients will sometimes have out-of-pocket costs even when their policy includes the medical treatment they need.

From 1 April 2019, the Australian Government introduced new rules to help make private health insurance simpler and easier for people to understand.

Four tiers of hospital cover began rolling out from early 2019 and became mandatory from 1 April 2020. All hospital insurance policies must be classified using the terminology gold, silver, bronze or basic. Policies that cover more than the minimum requirements can be called '+' policies, e.g., bronze+ or silver+.

What is, and is not, covered in these tiers is based on minimum standard categories of treatment. Gold-tier policies cover the most categories of treatment, with basic-tier policies covering the least. Each standard category — for example, 'bone, joint and muscle' category, or 'heart and vascular system' category — sets out the hospital treatments that must be covered by your private health insurer. If a policy covers a certain category, then it must cover all the treatments listed in it — not just some of them.

Medical and hospital costs

Doctor fees

Outside of public hospitals, most medical services are provided in a free market. In Australia, doctors are free to decide how much they charge for their services. The fee charged includes the value they place on their own professional skills, and their expertise to determine what they believe is fair and reasonable for the services they provide to each patient. A doctor's fee also needs to consider the costs of running a practice, including insurance, wages, rents, and equipment costs.

Doctors should have a billing policy for their practice, which includes:

- when payment is required
- any discounts available for early payment or charges for late payment
- acceptable forms of payment
- the name and contact details of a nominated person to discuss payment issues and problems.

Doctors should also have a cancellation policy, which is clearly communicated to patients before or at the time of booking an appointment.

Appropriate patient billing

All professional medical services provided should be billed, itemised, and described with the applicable MBS item. For services where there is no MBS item, a relevant item/fee from another schedule such as the AMA List of Medical Services and Fees ('AMA Fees List') should be billed.

A single episode of care or medical service should not be subject to a booking fee or a split bill.

The practice of charging booking fees and split billing are not supported and may breach a medical practitioner's agreement with the private health insurer. This includes where fees are not linked to an MBS or AMA Fees List item or part of a single bill.

Patients have the right to ask for an estimate of fees before they receive the service or agree to a proposed treatment.

Medical practitioners are legally able to request prepayment from a patient for a procedure. This is not the same as a booking fee or split billing. Medical practitioners should keep the time between prepayment and procedure to a minimum to reduce negative impacts on patients. The patient should also be made aware that they will not be able to make a claim to Medicare or their insurer in respect of that payment until the procedure has happened.

For services delivered in a hospital, the amount that a private health insurer may decide to pay is based on their own medical benefits schedules and may not represent the amount a doctor may believe is appropriate to charge as a fee. The amount different insurers pay for the same procedure can vary significantly — in some cases, by hundreds of dollars.

Out-of-hospital medical care as a private patient

Outpatient services

Outpatient services are a common part of many people's treatment. Typical outpatient services include visiting a medical specialist at their practice or having pathology and radiology tests done.

Health insurers do not pay any benefits for these kinds of outpatient services. If the patient is being treated as a private patient, these services are funded in part by the patient and in part by the MBS rebate (85 per cent of the scheduled fee).

Sometimes this outpatient service may be billed at the Medicare rebate level (rebate only or bulk-billed). When the Medicare rebate is less than the doctor's fee, the patient will have out-of-pocket costs after being reimbursed by Medicare.

Hospital substitution services

Historically, insurers have only provided cover for in-hospital treatments, except for optional extras packages for dental and allied health treatment.

However, in recent years, some insurers have started providing out-of-hospital schemes for their own policyholders, such as joint replacement rehabilitation at home.

Patients whose insurer offers cover for hospital-substitution care are advised to check the details of these schemes carefully before using them to reduce the risk of incurring unexpected out-of-pocket costs.

Hospital treatment and fees

Public patients

All Australians can access inpatient (in-hospital) treatment as a public patient in a public hospital free of charge, as these services are funded by both federal and state/territory governments.

However, public hospital patients are not able to choose the hospital they are admitted to or the doctors who will treat them. There can also be wait times for non-emergency services.

If there is an outpatient component of the public hospital treatment, the patient may need to make a payment towards the service.

Private patients

Private hospitals are available to all Australians who wish to pay to use their services. Everyone's situation is unique, and how much a person pays depends on:

- if they have private health insurance
- if their insurance covers the treatment — some policies do not provide much cover
- the arrangement the doctor has with the patient's insurer to provide the service, such as a no-gap arrangement or known-gap arrangement (see page 7 for more details)
- the specific contractual arrangements (if any) between the hospital and the health fund.

When a person has hospital treatment as a private patient, Medicare will pay 75 per cent of the MBS fee for the service provided. If they have private health insurance, the insurer must pay at least 25 per cent of the MBS fee, unless they agree to pay more.

Health insurance policies are expensive. It is important to be aware that a policy may not cover all aspects of treatment, or all costs.

If you are uncertain about the level of rebate from your private health insurer that applies to your medical service at the private hospital you intend to be admitted to, you should contact your insurer with the relevant MBS item number provided by your doctor.

How out-of-pocket medical costs can arise

An out-of-pocket cost arises when the amount covered by the MBS, and/or private health insurance, does not cover the full fee for a service.

MBS benefits and private health insurance rebates have not kept pace with inflation. Doctors' costs (which include rent, electricity, staff wages, supplies and insurance) have continued to increase and this disparity is one cause of increasing out-of-pocket costs for individuals.

Not all insurance policies cover all procedures, which can also result in out-of-pocket costs.

In addition, some doctors will have arrangements with insurers that can affect out-of-pocket costs, including:

- no-gap arrangement — where the doctor has agreed with the insurer to only bill the patient the amount the insurer has set for that particular service – the patient has no out-of-pocket costs
- known-gap arrangement, which allows the doctor to charge a set amount (usually up to $500) above the insurer's agreed amount that they will pay. The patient pays this known-gap amount as an out-of-pocket cost.

When there is no arrangement between a doctor and an insurer, or the doctor charges more than the known-gap arrangement, a patient's out-of-pocket costs can significantly increase.

This is because the insurer will only pay the minimum benefit amount required — 25 per cent of the MBS fee. Lower benefits paid by the insurer mean higher out-of-pocket costs. If not communicated early, this can be confusing for patients.

Table 1 shows the different types of payments for the treating doctor's services that patients who hold private health insurance may have (no-gap, known-gap, no arrangement).

However, patients should be aware that even if they opt to be treated as a private patient in a public hospital, they may end up with some additional charges.

Using a knee replacement (MBS item 49518) as an example, the table shows these three billing and payment scenarios where the doctor's fee is more than the MBS schedule fee.

Table 1: Three payment scenarios for a knee replacement (MBS 49518) *

	Doctor's fee	MBS rebate (75%)	PHI medical benefit	Out-of-pocket cost
Doctor accepts the PHI medical benefit amount at **no-gap**	$2,386.75	$1,087.95	$1,298.80	$0.00
Doctor accepts PHI **known-gap** arrangement	$2757.85	$1,087.95	$1,169.90	$500.00
No arrangement - the PHI benefit amount does not cover the doctor's fees**	$3,000.00	$1,087.95	$362.64	$1,549.410

**Table is based on hypothetical doctor's fees for a single service only. Additional, associated service charges are not included (e.g. hospital charges, anaesthetist, pathologist, radiologist and surgical assistant fees).*

***Whether a patient receives the full rebate versus the default 25 per cent is also dependent on arrangements made by the insurer and may vary depending on choice of doctor and choice of hospital.*

When medical fees can change

Sometimes a treatment plan needs to change, either during the operation, or over the course of treatment. Unexpected changes in a treatment plan may change the services delivered and therefore, the amount the patient is required to pay. Any changes to the treatment plan should be discussed in advance, if possible.

It is important to remember you may have more than one doctor involved in treating you — such as a surgeon, an assistant surgeon, an anaesthetist, plus any doctors handling any pathology or diagnostic imaging.

For a complete picture of your potential out-of-pocket costs, you should ensure that every doctor or health professional involved in your care provides you with an estimate of their fees.

Summary of where out-of-pocket medical costs can arise:

- known-gap arrangements between doctors and private health insurers — out-of-pockets will be up to an agreed amount (usually up to $500)
- no arrangements with private health insurer — doctor's fee is greater than the private health insurer rebate
- outpatient services (i.e. pathology tests, diagnostic imaging)
- treatment as a private patient in a public hospital
- a private health insurance policy does not cover the full cost of MBS services
- services billed for are not linked to MBS or AMA items
- non-MBS items are billed for (i.e. a facility fee).

Excessive fees

Excessive fees — fees that the majority of a doctor's peers would consider to be unacceptable — are not supported by the AMA.

Furthermore, the practice of charging a second, separate bill — often known as a booking fee or a split bill — for medical services is not supported.

Many medical colleges, associations and societies have taken it upon themselves to set up complaints processes to support consumers, and consumers are encouraged to contact these organisations if assistance is required.

Disputing reimbursement with a private health insurer

When submitting invoices to private health insurers for reimbursement, it is helpful to include a cover sheet listing the date of the bills, the provider's name, MBS items billed, and the total amount of the bill. When reimbursement is made, the private health insurer will send the patient a summary of bills paid and the total amount reimbursed. If a bill is rejected, there is normally a short explanation for the rejection.

If a patient has submitted a bill to an insurer that they think should have been reimbursed, but was rejected, they should talk to the insurance company and ask for a more detailed explanation for the rejection.

Most private health insurers will have employed agents to help in settling these disputes. It never hurts to ask how much help they can offer.

Some doctors are paid directly by the health insurers, and some have an agency that does their billing for them.

Doctors and patients are encouraged to be aware of the advice provided by the Private Health Insurance Ombudsman on medical billing, and what consumers can do when a medical bill is much higher than expected.

For more information, contact the free Private Health Insurance Ombudsman service:

Online: https://www.ombudsman.gov.au/complaints/private-health-insurance-complaints

Phone: 1300 362 072

Informed financial agreement

An agreement between a doctor and a patient

The doctor-patient relationship is a partnership. Working together, we can achieve better healthcare outcomes. The relationship is built on mutual respect, communication, and trust.

This means both parties ask questions and provide information to agree on a treatment plan, together.

This section provides general information on how to understand what an episode of medical treatment might cost. This is known as an informed financial consent between a patient and their doctor.

There are a range of circumstances where a doctor may find it difficult to provide full informed financial consent. These include in a medical emergency or if there is an unexpected complication.

The Australian Government amended the rules for private health insurance so that from 1 April 2020 private hospital cover has been classified in 4 tiers — gold, silver, bronze or basic.

What is, and is not, covered in these tiers is based on minimum standard clinical categories. Clinical categories are types of hospital treatments described in a standard way. The higher the tier, the more categories it covers.

If your health insurer covers a category — for example, 'bone, joint and muscle' or 'heart and vascular system' — they must cover all the treatments in that category, including all unplanned treatment that is provided as part of a planned surgery.

Further information on these reforms can be found at the federal government's private health website, www.privatehealth.gov.au.

Good informed financial consent can help remove any surprises from medical costs, and help a patient understand where medical fees can come from. Ultimately, informed financial consent outlines what a patient may have to pay for medical services.

If doctors have a financial interest in the facility carrying out the medical care, this must be disclosed to the patient. Good informed financial consent should include disclosure to patients of any interests in matters related to their care, including financial interests in the facilities used or financial gain from the use of devices.

What happens at a specialist medical consultation?

To give them more options, patients can ask their GP to recommend a number of specialists.
Non-GP specialists work in clinics, public and/or private hospitals.

When booking the initial consultation with the specialist, patients should ask about the cost, noting Medicare only pays for a portion of most initial consultations.

It is important that patients understand everything the specialist tells them. It is a good idea for patients to ask questions, take notes, or have a support person.

At a specialist consultation, the specialist and patient (and/or the patient's support person) may talk about:

- the patient's personal and family medical history
- current symptoms the patient may be experiencing
- the patient's lifestyle factors such as diet, exercise, hobbies, and generally how they are feeling every day
- medication being taken, including over-the-counter medicines and nutritional/herbal supplements
- any side effects the patient may have from their medicine/s.

The treating specialist will then discuss their diagnosis with the patient and give a recommendation on appropriate treatment options available. This could include the need for surgery, medication, or ongoing monitoring with the patient's regular GP.

It is a good idea to talk about costs at a patient's first visit. It is also important that a patient's usual GP is aware of the treatment plan to ensure high-quality, continuity of care.

Patients should be aware that not all medications, tests and treatments are subsidised by the government and this is not under the control of their medical practitioner. When ordering or prescribing such tests, medicines or treatments, the doctor or patients should be informed clearly that there is no rebate available.

Ongoing or long-term care

Many patients have ongoing or chronic illnesses and see medical practitioners regularly; this can result in cumulative out-of-pocket expenses and increased financial stress. Medical practitioners should inform patients about the cost of each visit and should review this information at appropriate intervals.

Questions to ask your doctors

This is a sample list of questions you may wish to ask your doctor:

- What are your fees?
- Are there any fees for other doctors?
- Is there a Medicare rebate for this and how much is it?
- Will I have any out-of-pocket costs?
- Is your fee an estimate only?
- Can I have an estimate of your fees in writing?
- If the cost changes, when will you let me know?
- What if I need a prosthesis/implant?
- Should I contact my health fund?

Remember: If you are unclear about the total costs of your treatment, ask your doctor and your health fund.

What if surgery or other medical intervention is required?

Where surgical or other medical intervention (e.g. radiotherapy, ongoing consultations) is an option, it is important to discuss and agree:

- why the operation or medical intervention is needed
- how the operation or medical intervention will be performed or provided, and where (e.g. hospital operating theatre, day hospital, consulting room)
- who will be part of the surgical or medical team (i.e. anaesthetist, assistant surgeon, physiotherapist, psychiatrist, medical oncologist etc.)
- what the risks, benefits, and possible complications for the operation or medical treatment are
- what the patient will need to do before the operation/intervention, such as any tests, fasting or special diet, and ceasing any medication they may be taking
- expected recovery time from surgery or medical intervention in terms of treatment, medication, diet, and home care, based on the patient's health status prior to the procedure being performed
- what the post recovery plan is (e.g. physiotherapy, exercises at home)
- when the patient will be able to return to regular activities (e.g. work, driving, lifting, and exercise)
- whether or not the patient has private health insurance, and the patient's ability to pay for the surgery or medical intervention.

Disputing a fee with the doctor

Before a fee is charged by the doctor, the doctor should ensure the patient has received all the required information so they can provide an informed financial consent that includes the cost estimate for each service provided, including the MBS item numbers.

It is a good idea for patients to keep records of their medical invoices. If a patient feels their charges were not agreed to, they should contact their doctor's office to discuss the reasons for the various charges, and why they are more than expected.

AMA resources

The AMA has a number of public position statements and resources relevant to medical fees:

- Setting medical fees and billing practices (2024)
- Informed financial consent position statement (2024)
- AMA Private Health Insurance Report Card (2023). This is an annual report, so check the AMA website to see if there is a more recent version.

Australian Government information

The Australian Government hosts a website, https://www.privatehealth.gov.au that provides:

- more detailed information about how private health insurance works
- a tool for comparing the features of policies
- the Private Health Information Statements for every policy.

The Australian Government also hosts a website that provides a tool to help consumers find and understand costs for medical specialists, at https://medicalcostsfinder.health.gov.au/

On the website, patients can enter the name or MBS item number of a procedure, which will bring up information about the median out-of-pocket costs patients typically pay. For each procedure, users can also see median fee information by Australian state/territory, the MBS rebate for the item, and insurer rebates to insured patients.

Recently, the website has been updated to allow individual private health insurers and individual medical specialists to list their rebates/indicative fees for common medical procedures should they wish to do so.

The AMA encourages its members to list indicative fees and any gap arrangements for select high volume services on the medical costs finder website, noting that participation is voluntary. The website makes it clear that information published on the site is a guide only and is not a substitute for a medical quote or informed financial consent.

PHIO

The Private Health Insurance Ombudsman (PHIO) protects the interests of people covered by private health insurance. It carries out this role in a number of ways, including providing an independent complaints handling service.

If a consumer requires further assistance, or wants to lodge a complaint about a private health insurer, they can contact PHIO directly on 1300 362 072 or through the website at https://www.ombudsman.gov.au/complaints/private-health-insurance-complaints

MBS Online

The Medicare Benefits Schedule (MBS) Online contains a listing of the Medicare services subsidised by the Australian Government. Search the MBS for all the latest fees and information at https://www.mbsonline.gov.au/

More information about medical fees

To read more about how the healthcare system funds Australians' medical care, visit the AMA guide for patients on how the healthcare system funds medical care.

ESTIMATE OF MEDICAL FEES

This is an estimate of medical fees only. It does not cover costs of medicines (e.g. including those listed on the Pharmaceutical Benefits Scheme (PBS) or not listed on the scheme i.e. non-PBS), drug administration and related costs that may be incurred for certain treatments (e.g. chemotherapy or other medications for cancer), particularly for ongoing treatment that extend over a long period of time.

PATIENT'S DETAILS

To be completed by the patient

Family name:	First name	
Address:		Suburb/City:
State:	Postcode:	Date of birth: ___/___ /_____
Hospital:		Admission date: ___/___ /_____
Medicare: Yes ☐ (number) _____ No ☐		Health fund:

To be completed with the treating practitioner

MBS Item No	Description	Doctor's Fees	Medicare Benefit	Health fund benefit (estimate)	Estimated patient gap
Total:					

OTHER RELATED SERVICES (if applicable)

Type of Service (Tick if likely to be involved)		**Estimate of Fee or Charge**	**Contact for fee information** (if known)
Anaesthetist	☐		
Surgical Assistant	☐		
Pathology	☐		
Imaging	☐		
Devices/Implants	☐		
Other health professional	☐		
Other health professional	☐		

DECLARATION BY PATIENT OR GUARDIAN:

I understand that this is an estimate only and may be subject to variation. I acknowledge that it is my responsibility to confirm with my health insurance fund the level of cover that I have and any amount that it will be my responsibility to pay. I have been advised that other health professionals may be involved in my treatment and I understand that this estimate does not include their fees or charges unless specifically stated otherwise.

Patient or Guardian's signature:	Date: ___/___ /_____
Guardian's full name:	

AUSTRALIAN MEDICAL ASSOCIATION
T | 61 2 6270 5400 **F** | 61 2 6270 5499 **E** | info@ama.com.au
39 Brisbane Ave, Barton ACT 2600 | PO Box 6090, Kingston ACT 2604
www.ama.com.au