Submission by the Australian Nursing and Midwifery Federation

Submission to the Department of Health, Disability and Ageing – Fee Transparency in Health Care on Informed Financial Consent and Split Billing Practices

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Key Points

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country. The ANMF thanks the Department of Health, Disability and Ageing for the opportunity to provide feedback on the Fee Transparency in Health Care: Informed Financial Consent and Split Billing Practices consultation.

2. Health consumers report trust in the quality and reliability of Australia's healthcare system,[1] however, confidence in affordability remains low.[2] Limited access to clear, upfront cost information contributes to delayed or forgone care and unexpected out-of-pocket expenses ("bill shock").[2-4]

3. Existing informed financial consent (IFC) standards are largely voluntary and inconsistently applied. Many current frameworks place a dual responsibility on consumers to initiate cost discussions instead of requiring providers to proactively provide this information, perpetuating ongoing issues with financial transparency and practices such as split billing.

4. The ANMF supports establishing a legally enforceable IFC standard that requires providers to deliver clear, accessible, written cost information, including a single, itemised estimate of all actual and potential fees.

5. Implementation should be supported by workforce training, practical resources, and digital tools to streamline IFC processes and minimise administrative burden. A standardised template should be developed to define minimum information requirements and act as a compliance benchmark.

6. Providers who fail to meet established IFC requirements should face penalties that are proportionate to the seriousness of the non-disclosure or misrepresentation of costs. This must be accompanied by clear accountability standards that place IFC obligations on the

billing provider and do not shift this onto other practitioners such as nurses and midwives, who are often involved in consumer communication but are not responsible for setting fees unless in private practice.

7. A clear, accessible complaints pathway should be introduced for IFC and split billing concerns, including mechanisms for reimbursement, financial support, or compensation where charges substantially exceed estimates or IFC is not provided.

Introduction

8. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.

9. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

10. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

11. The ANMF thanks the Department of Health, Disability and Ageing for the opportunity to provide feedback on the Consultation Paper 'Fee Transparency in Health Care: Informed Financial Consent and Split Billing Practices'.

Consultation Questions

Informed Financial Consent

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

12. The ANMF supports reforms to strengthen fee transparency in health care, including the introduction of mandatory and legally enforceable informed financial consent (IFC).

13. When consumers seek care, they are often vulnerable and distressed. This is compounded by inherently imbalanced power relationships with medical practitioners, on whom they rely to accurately diagnose their condition and advise on appropriate treatment options. As a result, consumers may have limited control over the care they receive, including their ability to understand and make informed decisions about its cost.

14. Consumers are often ill-equipped or uncomfortable asking about costs, and even when this information is provided, they may lack the knowledge needed to assess whether fees are reasonable. Further, some consumers may perceive that requesting lower-cost treatment alternatives will result in receiving lower-quality care. This perception can discourage them from discussing more affordable options. As a result, medical providers may recommend treatments that generate higher fees and provide greater financial benefit to the provider, rather than recommending the option that best meets the consumer's needs.

15. While ethical billing is an expected practice, the absence of a standardised framework and clear obligations means that consumers are not always given the opportunity to provide informed financial consent (IFC) before treatment. As a result, they may experience “bill shock” when treatment costs exceed their expectations or financial capacity. This financial strain can undermine the benefits of care, as patients may delay or avoid follow-up treatment, experience stress, or face ongoing health risks while managing unexpected medical debt.

16. While Australia has a robust public healthcare system and Medicare covers many types of care, not all types of care are subsidised. The cost of these health services remains a

significant barrier to care-seeking behaviours, particularly for those with more limited financial resources. These people are also often among the most vulnerable members of the community who are at risk of poorer health and wellbeing outcomes and experiences.

a) The 2026 Mandala report, Restoring affordable access to specialist care in Australia, estimated that one in ten (around 0.9 million) Australians aged 15 and over delayed or did not seek specialist medical services they required due to concerns with the associated fees.[5, 6]

b) The 2025 *Consumers Health Forum of Australia (CHF) National Consumer Sentiment Survey (NCSS)* found that unaffordability of healthcare was the most common reason to avoid seeking health services, including dental care (67.0%), prescriptions or necessary treatments (54.2%), and medical tests or treatment and appointments recommended by a doctor (48.7%).[3]

c) The 2026 *CHF NCSS* survey found that consumers faced barriers to accessing clear information about upfront costs of medical services. Findings suggest that consumers' cost concerns are not just price-related, but also driven by uncertainty about the cost of care services.[2, 3]

d) The 2024 *CommBank Patient Insights Report* survey supports this, finding that one in three respondents found navigating payments and claims complicated, one in five had forgone appointments due to opaque billing, and one in three had experienced bill shock due to unexpected charges or out-of-pocket expenses when accessing specialist services.[4]

17. These findings highlight the extent of cost-related barriers, particularly around accessing clear billing information. To address these issues, the ANMF recommends making upfront pricing mandatory and legally enforced, requiring providers to publish price lists and provide full itemised quotes to consumers before treatment commences. This would help to ensure consumers are informed of the full expected cost of treatment in advance, supporting

informed choice and financial fairness.

18. While acknowledging that current IFC standards have been established as best practice, and are often required by hospital, insurer, and professional policies, there are no current universal legal obligations. The lack of an enforceable standardised approach makes accountability difficult and creates challenges around determining when fee information is not provided clearly or early enough.

19. Further, without clear standards and enforcement, there is doubt that providers will meet such requirements. This was illustrated when, in 2019, the Coalition Government launched the *Medical Costs Finder* as a voluntary transparency tool for specialist fees, intended to help patients compare prices in advance and reduce surprise out-of-pocket costs. While, in principle, a good idea, the initiative was largely unsuccessful due to extremely limited participation by medical providers. By the end of 2022, of around 6,300 eligible specialists registered to practise in the 11 specialties included on the Medical Costs Finder, just six doctors had chosen to voluntarily display their fee information. Three years on, only around 88 doctors have voluntarily displayed their fee information.[7] To resolve this issue, in February 2026, the Labor Government introduced the 'Health Legislation Amendment (Improving Choice and Transparency for Private Health Consumers) Bill 2026', which permits the government to publish details of what individual specialists charge for specified services.[7] The necessity of this bill reflects the failure of a voluntary model to achieve meaningful disclosure. It also indicates that, without enforceable requirements, transparency standards are unlikely to be consistently adopted in practice.

20. The establishment of a strong and fair regulatory framework is essential to ensure accountability in health service delivery, including the transparency of costs that underpin patient consent. This is in line with the Australian Competition and Consumer Commission's (ACCC's) continued concern about consumers' access to information about the cost of, and financial interests in, those providing medical services.[8]

21. Evidence demonstrates that many Australians find accessing information around healthcare costs challenging,[2-5] and many are likely unaware of clinicians' professional standards around IFC and their own rights as health consumers. Establishing a legal obligation that places responsibility on providers to proactively deliver all relevant information in a clear and accessible manner, rather than relying on consumers to initiate discussions or seek information from multiple sources, is the most effective way to ensure IFC is consistently implemented.

22. Ahpra and/or another health complaints agency could serve as the bodies responsible for monitoring, investigating, and enforcing compliance with informed financial consent requirements by relying on the existing regulatory powers contained within the National Law provisions.

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

23. Providers who fail to meet established IFC requirements should face penalties that are proportionate to the seriousness of the non-disclosure or misrepresentation of costs. A legally enforceable IFC regime would create a real incentive for providers to give clear, timely, and accurate cost information, reducing bill shock and improving consumer trust. This is especially important for consumers who are more vulnerable to financial harm, including unemployed people, older people, Aboriginal and Torres Strait Islander Peoples, culturally and linguistically diverse (CALD) community members, and others who may be less able to challenge unclear billing practices. Without meaningful enforcement, voluntary compliance is unlikely to be enough to achieve consistent transparency.[2, 3]

24. As will be articulated in response to Question 9, these IFC obligations and penalties for not meeting them must clearly apply to the billing provider and not be shifted onto other practitioners such as nurses and midwives, who are often involved in patient communication but are not responsible for setting fees.

25. The framework should also allow affected consumers to obtain compensation, financial support, or reimbursement where fees charged are unreasonably outside the IFC estimate, or IFC has not been provided. That would create a remedy for consumers who have suffered financial harm because of poor disclosure practices and is likely to improve consumers' awareness of providers' IFC responsibilities. In practical terms, this could be handled through complaint pathways, refund obligations, or other restitution mechanisms linked to the seriousness of the breach.

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

26. A regulatory approach which establishes mandatory requirements supported by legally enforceable standards is the most effective mechanism for strengthening IFC. Such an approach should embed IFC as a core and routine component of care delivery across all care sectors, rather than an optional or discretionary activity. Importantly, this framework must impose a proactive obligation on providers to demonstrate that IFC has been delivered in accordance with defined standards, with appropriate documentation that can be monitored, measured, and audited. This shifts the onus away from consumers having to identify and report failures and instead places responsibility on providers to ensure compliance.

27. To support this, existing compliance and enforcement mechanisms should be strengthened. This may include expanding the role of the Australian Commission on Safety and Quality in Health Care (ACSQHC) or the Australian Competition and Consumer Commission (ACCC) to independently monitor and undertake compliance action where requirements are not met. This would enhance transparency, accountability, and public confidence in the system.

28. The ANMF emphasises that reliance on voluntary compliance represents the least effective regulatory option, as it lacks enforceability, consistency, and accountability. Evidence from existing self-regulatory models demonstrates that without clear obligations, uptake is insufficient to drive meaningful or sustained change in practice. Continuing to prioritise voluntary approaches would risk perpetuating current gaps in IFC delivery and undermining

efforts to improve patient-centred care.

29. Any strengthened regulatory framework must be accompanied by education, training, and clear, accessible guidance for health providers and the workforce. This includes ensuring that practitioners understand their legal obligations and role in ensuring IFC is delivered. In addition, as will be detailed in response to Questions 13 and 14, implementation must be supported by enabling measures that facilitate compliance without imposing disproportionate administrative or regulatory burden. This includes streamlined documentation processes, integration with existing clinical workflows and digital systems, and alignment with other regulatory and accreditation requirements. A balanced approach is required to ensure that regulatory strengthening improves IFC delivery in practice without detracting from direct patient care.

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)?

30. IFC should require disclosure of the full anticipated cost of care for the entire episode of treatment, not just the fee charged by the primary provider. This should include, where relevant, fees charged separately by anaesthetists, assistant surgeons, pathologists, imaging providers, devices, hospital or facility charges, telehealth, follow-up care, etc. If complete information cannot be obtained, the provider must clearly state that the figure is an estimate, explain the limitation, and provide the best available breakdown of expected charges. Disclosure should also cover expected out-of-pocket costs, applicable Medicare rebates, private health insurance benefits, and any lower-cost alternatives that are clinically appropriate.

31. To enable the creation of an IFC that covers all of the above, robust information sharing systems regarding the cost of care must be established. This will require the establishment of digital systems, as will be outlined in response to Question 15.

9) Who should IFC obligations apply to?

32. IFC obligations should apply to all registered health providers who are billing for services rendered. The obligation must sit solely with the billing provider who controls the charge and is accountable for disclosure. That obligation should not be shifted onto other practitioners including nurses and midwives. Nurses and midwives are often involved in patient communication but are not responsible for setting fees unless they are themselves practising privately (i.e., nurse practitioners, endorsed midwives). Nurses and midwives who do not work in private practice arrangements have a role in advocating and informing consumers to understand their planned care and associated fees (and should be recognised for this), but do not bear primary liability for confirming IFC. Where a nurse or midwife is themselves the billing provider, then they should reasonably be subject to the same disclosure obligations as any other fee-setting provider.

33. IFC is also relevant to patients receiving care in public hospitals who are asked to elect between public and private patient status. Patients may not fully understand the financial implications of this decision, including potential medical, accommodation and diagnostic charges. Nurses and midwives are frequently involved in supporting patients through admission and election processes and should be provided with appropriate education and resources to assist patients to understand the consequences of their choices without assuming responsibility for fee disclosure.

10) What information should IFC reasonably require providers to disclose?

34. IFC must include all of the information outlined in the survey. This includes:

    a. Expected fees charged by the provider: best estimate of the fee that will be charged for the proposed service as a total, alongside a full breakdown of amounts for all fees associated with the service. Where fees are estimates, this must be clearly marked, and details must be provided as to why the real amount cannot be provided.

    b. Likely out of pocket costs (gap): a clear amount or estimate of the consumer's

expected out-of-pocket payment after Medicare rebates and private health insurance benefits are applied.

c. Costs billed by other practitioners: identification of all other practitioners or services likely to be required in the same episode (e.g., anaesthetist, assistant surgeon, imaging, pathology, prostheses, device suppliers), and a clear amount or estimate when costs are unknown.

d. Range of possible costs and uncertainties: details of how all estimated costs have been calculated as well as explicit description of situations that could change the estimate (e.g., complications, changes in procedure, additional tests), with an approximate additional cost range.

e. Treatment alternatives and cost implications: details of alternative treatments or providers (including public/no-gap options) with comparative cost implications and trade-offs in outcomes, risks, wait times, etc.

f. Timing and format of disclosure: details, including dates, of when payments will be requested (deposits, pre-admission payments, on discharge) and accepted payment methods.

g. Relevant Medicare Benefit item number/rebate: list of item numbers, the current MBS rebate for each, and which components of the episode they apply to.

h. Private health insurance benefit: the consumer's likely PHI benefit (including whether a no-gap/gap arrangement may apply), plus a recommended prompt for patients to confirm details with their insurer. Further, as many people have limited understanding of private health insurance products, including exclusions, excesses, co-payments and gap arrangements, IFC requirements must ensure information is provided in plain language and clearly identifies any limitations in available insurance information at the time consent is obtained.

35. IFC requirements should be set out in a standardised template to support clear and consistent disclosure provided in writing. This template should also include the date and time at which IFC occurred, provide a place for consumers to acknowledge receiving and consenting to this information with an expectation that they will be billed in the agreed-upon way to an amount indicated by the provided estimate. This template should also serve as a consumer handout that can be saved for their records and provides information on who to contact for billing questions, how to dispute a bill, available financial counselling/support services, and the consumer's rights (including any refund/complaint pathways).

11) Should IFC be provided in writing? Are there any exemptions?

36. As outlined in response to Question 10, IFC should be provided in writing in all instances. Putting this information in writing would serve as a clear compliance marker that consumers have been provided with all the information required to make an informed financial decision. This information should be presented in a consumer-friendly format that is easy to understand, including by those from non-English speaking backgrounds and those with low levels of financial and/or health literacy. This may require the creation of both detailed and simplified versions of the IFC templates, with both being made available to ensure that providers cannot opt to provide simplified versions that avoid detailed disclosure requirements.

37. While providing IFC in writing should be established as the preferred norm, there may be situations where this is not feasible. This includes in the case of emergency or urgent care, where taking the time to cost care and present an IFC would place the consumer at risk. Decision-making tools should be developed to inform when this exemption applies, as it is unfair to place clinicians in a position where they are forced to choose between patient safety and their ethical code or a compliance breach. In those cases, verbal disclosure may be used, with written confirmation provided as soon as practicable afterwards. Importantly, these exemptions should not be used to avoid transparency or avoid responsibility.

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

38. It is beyond the remit of the ANMF to provide comment related to existing professional codes of conduct. However, it is noted that some of these existing professional codes of conduct set out that the responsibility for IFC share is shared between practitioners and patients. The ANMF considers that it is the practitioner's responsibility to deliver clear IFC and should not be reliant upon being prompted by concerned patients. As outlined in response to Question 5, consumers are often unaware of their rights and may not ask for this information due to the relationship power imbalance.

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

39. Creating a legally mandated IFC requirement will require a coordinated package of supports across provider capability, consumer awareness, system design and regulatory settings.

40. To ensure awareness and compliance, the IFC framework should be underpinned by comprehensive, sector-wide education and training. This should clearly set out the roles and responsibilities of all practitioners in meeting IFC obligations. Training should also cover any new digital tools, templates or systems introduced to support compliance. Regulatory changes must be communicated clearly, consistently and in a timely manner to reduce the risk of inadvertent non-compliance arising from lack of awareness.

41. Consumers should be supported through clear, accessible public communication about IFC requirements and their rights. This should include plain-language information on what IFC is, what consumers should expect from providers, and how to identify and respond to potential non-compliance. Consumer-facing materials should also explain that the primary responsibility for providing compliant IFC rests with the provider. Consumers should also have access to pathways to raise concerns, including concerns about inappropriate charging practices or failures to provide adequate IFC. These pathways should be simple to use and supported by appropriate oversight and response mechanisms. Consumers should be

informed of these processes as part of the IFC process itself.

42. Attention should be given to ensuring informed financial consent processes are culturally safe and accessible for Aboriginal and Torres Strait Islander Peoples. This may include the development of culturally appropriate resources, engagement with Aboriginal Community Controlled Health Organisations, interpreter services where required and tailored communication approaches that recognise differing levels of health, financial and digital literacy.

43. As mentioned in response to Questions 10 and 11, to support IFC being delivered in a comprehensive manner that provides all relevant information, standardised templates for providers should be developed. These templates can then be used to clearly communicate this information with consumers, ensure that minimum information requirements are met, and establish a consistent documentation process to support implementation and reduce variability.

44. Templates should be supported by digital tools that enable efficient creation, sharing, and storage of IFC information. Where possible, such tools should integrate with existing clinical and billing systems to minimise administrative burden and support routine use.

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

45. Reforms to improve IFC should be designed to strengthen transparency and consumer protections without creating new barriers to care or imposing disproportionate administrative burdens on providers. In particular, reforms should avoid shifting responsibility for IFC onto nurses, midwives, or other clinical and administrative staff who are not responsible for setting fees or billing patients. They should also avoid relying exclusively on digital processes, introducing overly complex forms or compliance requirements, or creating exemptions that weaken protections for vulnerable consumers or those with lower levels of health or digital literacy.

46. Consideration should also be given to people living in rural, regional and remote communities. These people may need to travel considerable distances to access specialist care and often have limited capacity to seek alternative providers. Early disclosure of likely costs, including before travel or accommodation arrangements are made, is essential to support informed decision-making and reduce financial hardship.

47. IFC reforms should support, rather than delay, access to timely care. While urgent care must not be impeded, consumers receiving planned or elective care should be given sufficient time to understand anticipated costs, compare available options, ask questions, and seek independent advice before making financial commitments.

48. An important implementation risk is the increased administrative burden associated with strengthened IFC requirements. Although this should not prevent reform, additional coordination, documentation and communication requirements may increase costs for providers, particularly where a single, consolidated estimate or bill is required across multiple practitioners and services involved in an episode of care. Without appropriate implementation support, standardised systems and streamlined processes, these additional compliance costs may ultimately be passed on to patients through higher administration fees, increased service charges or other cost recovery mechanisms. There is also a risk that providers may respond by shifting costs into less transparent areas, such as bundled charges or administrative fees, undermining the objectives of IFC reforms. These responses should be monitored by the relevant regulatory bodies, with mechanisms to identify and address unintended cost shifting.

49. Reforms should avoid creating incentives for providers to substantially overestimate anticipated costs in order to minimise regulatory or legal liability. Cost estimates should be comprehensive and transparent, and requirements should recognise that clinical circumstances may change while encouraging reasonable accuracy rather than defensive quoting practices that may discourage people from pursuing care. Increased regulatory expectations should not reduce the quality or usefulness of cost estimates. IFC requirements

should therefore emphasise transparency and reasonable accuracy, recognising that estimates may change where clinically justified and that providers should explain the circumstances in which costs may vary.

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

50. Digital tools must complement, not replace, verbal discussion and culturally safe and responsive patient communication. They must be accessible, available in plain language and multiple languages, and supported by non-digital options for consumers who cannot or do not wish to use online systems. This must be proposed as part of the reform package and align with the regulatory emphasis on practical implementation supports and patient access.

51. Digital pricing and comparison tools may improve transparency, however, they should be designed to carefully avoid any unintended consequences. Evidence suggests that variation in Australian private specialist fees and out-of-pocket costs is largely driven by physician-specific differences, rather than patient characteristics or clinical risk.[9] A key factor that may drive price variation is the perception of quality or skill differences between physicians, as perceived by consumers or physicians themselves. The ability to price differentiate based on quality perception contributes to the market power commanded by physicians, which can lead to large price variation and non-transparency of fees. To avoid these unintended consequences, digital comparison tools should integrate both cost and relevant quality or outcome information to support genuinely informed decision-making.

52. Beyond comparison tools, digital infrastructure could enable more coordinated and consumer-centred billing practices. Shared platforms that allow multiple providers involved in a single episode of care to contribute cost information could generate consolidated, itemised estimates for patients, reducing the need to navigate separate invoices and improving clarity about total expected costs. These systems could also support providers by automating the generation of standardised IFC documents, linking Medicare Benefits Schedule (MBS) items, rebates, and private health insurance information, and recording when IFC has been provided. Embedding typical costs and public “no-gap” options into e-

referrals, for example through links to tools such as *Medical Cost Finder*, could ensure patients receive relevant financial information at the point of referral to support their decision-making.

Split billing

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

53. Providers should be required to issue a single bill for all items/services associated with an episode of care. While a consolidated bill across a multi-provider episode may be operationally difficult due to multiple independent providers and billing systems, system-level supports such as standardised episode-of-care cost summaries and interoperable billing systems can address these challenges. As outlined in response to Question 13 and 15, robust supports and digital systems will be required to address these challenges, requiring coordination between hospitals, specialists, anaesthetists, pathology, and device suppliers.

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

54. System-level incentives that could support providers to issue a single bill may include requiring the lead provider to ensure consumers receive a complete cost estimate, even where multiple practitioners are involved. Exploring the use of digital tools to support shared billing platforms or systems that allow multiple providers to contribute to one consolidated estimate and invoice. With appropriate safeguards to ensure payments are passed on appropriately and consent from all parties, digital tools may also assist providers who receive a bundled payment for an episode of care to coordinate the costs across participating providers.

Miscellaneous

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

55. A key consideration currently missing is addressing the role of nurses and midwives as patient advocates and explicitly confirming they do not carry responsibility for financial consent unless they are the billing provider. While they play an important advocacy and communication role, care must be taken to ensure reforms do not create additional legal or administrative accountability for nurses and midwives where they do not control billing practices or fee-setting arrangements. Workforce education should clearly define roles and responsibilities across multidisciplinary teams.

56. If nurses and midwives or other healthcare professionals are to be covered under this scheme, then language and terminology throughout the document should be updated accordingly to ensure consistency, clarity, and appropriate application across the health workforce.

57. Greater attention should also be given to workforce education and training on informed financial consent, accessible and effective complaint pathways, patient remedies where financial consent obligations are not met, and safeguards against practices such as split billing or fragmented charging arrangements that may obscure the total cost of care.

58. The proposal should also give further consideration to the impacts on vulnerable groups, including culturally and linguistically diverse communities, Aboriginal and Torres Strait Islander People, older people, and regional, rural and remote patients, to ensure equitable access to clear, timely, and culturally safe informed financial consent processes.

Conclusion

59. The ANMF supports reform that strengthens IFC, improves fee transparency, and protects patients from unexpected costs. IFC should be legally enforceable, provided in writing for planned care, and include the total expected cost of an episode of care wherever practicable. Regulatory reform should be nationally consistent and supported by accessible complaint pathways and meaningful remedies for consumers.

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