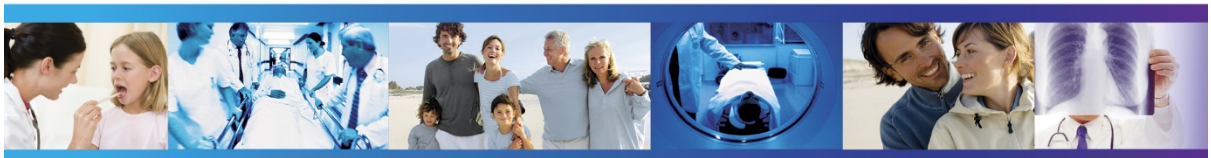
Private Healthcare Australia
Better Cover. Better Access. Better Care.



Combatting surprise billing in Australia

Exposure Draft - July 2021

Please provide any comments on this exposure draft by 15 August 2021

Contact:

Ben Harris, Director Policy and Research

ben.harris@pha.org.au

What is surprise billing?

Surprise billing is any charge that is not expected by the payer.

Large, unexpected costs are a major concern for the community, and they hurt the perception of private health insurance being value for money.[1]

In Australia, a medical practitioner may charge whatever fees they choose in the private system, including when practising as a private provider in a public hospital. The government is not able to regulate fees due to a clause in the Australian Constitution prohibiting civil conscription of doctors[2] (noting the limits of this provision have not been fully tested in the High Court).

As consumers and their agents, health funds, seek to reduce out of pocket costs, insurers and doctors have worked together to negotiate contracts that pay well in excess of MBS schedule fees. Contracted providers agree to provide services with no gap or a known gap, and in return they may receive long-term contract certainty, reduced administrative costs, and may get access to a larger volume of patients. Doctors who provide medical services without a contract get none of these benefits but can charge higher prices for their services.

In the March 2021 quarter, more than 97% of medical services covered by private health insurance had no gap (89.9%) or a known gap (7.7%).[3] The Grattan Institute has pointed out that just 7% of medical services account for 89% of medical gaps.[4]

Professional medical bodies, led by the Australian Medical Association, have been very strong in recent years about the need for informed financial consent, with their most recent policy document, *Informed Financial Consent: a collaboration between doctors and patients*, released September 2020.[5]

The Minister's Committee on out of pocket costs noted, "a minority of medical specialists have been charging very large fees, including to patients on low incomes. The Committee expressed serious concerns about such egregious charging."[6]

Egregious billing is practiced by fewer doctors than ever before. However, thousands of people still pay significant gap payments each week. Many of these consumers are surprised, shocked and disappointed by receiving large bills that they were not expecting.

All major advocacy groups in Australia support informed financial consent, where "doctors, hospitals and health insurers work together to provide information to patients about the costs associated with treatment, and the private health insurance benefits payable, prior to admission to hospital." [7]

Bills for private health services can come from a range of providers – medical practitioners and hospitals are the most common, but other bills may be levied by allied health services, diagnostic services or ancillary services.

Forms of surprise billing

There are four major types of surprise billing:

- High out of pocket charges not disclosed beforehand
- Split billing, where the full cost of the service is not disclosed to various payers
- Charges that are related to the service, but not described as part of the service (for example, 'administrative fees')
- Where the scope of service changed during the service (for example, where a complication in surgery required an unexpected intervention)

Charges not disclosed beforehand

This form of surprise billing occurs where a patient is charged an out of pocket cost that is not disclosed beforehand. In some cases, the patient may not even be aware of the service provided (for example, assistance at operations or pathology charges), let alone that they would receive a bill for it.

The major cost of this practice is borne by the consumer, who is unprepared for the bill and may lack the capacity to pay. Other costs are borne by the health funds and government, as providers may blame the gap payment on low rebates.

Split billing

This is where a provider does not disclose the full extent of their fees to payers.

For example, a doctor may charge a total of $2000 for a service where the MBS fee is $1000 and they don't have a contract with the insurer. That doctor may then bill the government $750 (the rebate amount for the service), bill the insurer $250 (the private health insurance rebate based on the MBS fee and no contract) and bill the patient $1000 directly. None of the payers know what the other has been billed, and the doctor is not being transparent about the full extent of their fees.

All payers bear the costs where there is a lack of transparency on fees. There is no public value in split billing.

Administrative or other fees

This is where a provider seeks to increase their income by charging a "booking" or an "administration" fee in addition to the medical fee by artificially claiming a fee is a different service to avoid meeting contractual obligations with no-gap or known-gap arrangements.

The AMA states, "If a medical practitioner has signed a contract with a private health insurer, the billing requirements must be adhered to. Circumventing contractual arrangements by issuing a second, separate bill for a single course of treatment is inappropriate."[8]

Costs for this practice are predominantly borne by the consumer, although health funds and governments are also affected. In particular, insurers and government may erroneously believe that a service has been provided without charge to the patient.

Changes to the scope of service

Medicine is an inexact undertaking. Occasionally planned outcomes go awry, and additional costs will be incurred. For example, if there are complications that require an unanticipated stay in the Intensive Care Unit, that will incur significant costs. The surprise in this instance is less about the billing and more about the scope of services needed. Complication rates for surgery in Australia are

very low indeed (approximately 2%),[9] with much lower rates of complications in private hospitals compared to public hospitals.[10]

Our experience is most patients understand the need for flexibility if an upfront quote for services is provided. Part of the informed financial consent process is to explain that if certain things go wrong, additional claims and charge may be incurred.

Evidence

Unexpected high bills

Research commissioned by the Department of Health and PHA by IPSOS in 2018 found, "Medical out of pocket expenses were a significant driver of discontent with the private system, particularly in the context of rising cost of living and increasing private health insurance premiums."[11]

IPSOS found that there was considerable confusion about what constitutes a gap payment, an excess payment, or other charge that left the patient out of pocket. However, it was clear that, "Attitudes towards out of pocket expenses vary according to whether patients are fully informed of costs in advance. Discontent was particularly intense among those not fully informed." [12]

One in three respondents (32%) were surprised by their gap – the majority knew of their gap in advance of their hospitalisation (68%).[13]

The higher the gap, the greater the negativity. Those surprised by their gap had more than double the negativity than those with a known gap. [14]

Medical fees

There has been a steady rise in the difference between fees charges for medical services and the MBS rebates for services since the introduction of Medicare in 1984.[15] The AMA and others point out that the increase in MBS fees has not kept up with inflation.[16] Above-MBS fees have increased significantly over the last ten years for specialist attendances, operations and anaesthetics.[17]

With the growing gap between the fees charged by doctors and the MBS rebate, health funds have increased rebates to doctors. In the September 2019 quarter alone, funds paid over $373 million additional to doctors above the MBS fee they are required to pay by law.[18] The AMA also argues that health fund rebates have not kept pace with costs, and "this is why patients may have out-of-pocket costs for medical services."[19] However, health fund rebates for medical fees have increased at a much higher rate than the MBS Schedule fee, and there is variation between funds' schedules.

The Grattan Institute notes that there are "a handful of specialists who bill their patients at more than twice the official Medicare Benefit Schedule fee. Only about 7 per cent of all in-hospital medical services are billed at this rate, yet these bills account for almost 90 per cent of all out-of-pocket medical costs for private hospital patients." [20] The data from the Australian Prudential Regulatory Authority suggests many of these high fees will actually be covered by no-gap or known-gap agreements with funds. [21]

Consumers are willing to change providers (or even go without care) to avoid medical gaps. The IPSOS survey found that possible gaps influence use of health care providers for 70% of those surveyed. [22] However, many consumers do not get this choice. The Consumers' Health Forum has found that, with respect to anaesthetists, many consumers "reported feeling disempowered and that they had no choice over the practitioner that they used." [23]

Hospital fees

Most hospitals have entered agreements with health funds to reduce out of pocket costs for their customers. There has been a decline in patients with private health insurance treated in hospitals without an agreement over recent years.[24] However, day hospitals are not (on average) moving with this trend. Day hospitals charge patients significantly higher out of pocket hospital fees than other private hospitals. In 2018-19, the average hospital gap payment across all separations per day in day

hospitals was $134, [25] compared to $63 per day for other private hospitals.[26] This gap has increased over the last five years by $24 for day hospitals and by $9 for other hospitals.[27]

Split billing and 'administrative' fees

There are no data available on the practice on splitting billing between patients, health funds and government. The lack of data is not surprising given the nature of the practice is to deceive. Health funds report that the practice is known to occur and is deemed to be rare but significant. The IPSOS survey noted that just under one in twenty (4%) of respondents indicated a fee for a single service was split across two or more invoices for one person/organisation. [28] This may be an indication of a provider seeking to avoid disclosure of the full fee.

The survey by IPSOS in 2018 suggested booking and administration fees are charged in about 11% of hospital admissions and other 'hidden' fees in about 5% of admissions.[29] Just fewer than one in ten (8%) of those who had claimed against their private hospital insurance said they had been charged a booking fee. Of those, 13% claim to be charged multiple booking, admission or other types of administration charges. [30] Common types of booking, admission or other administration charges as detailed by respondents included:

- Hospital admission fees/charges, hospital stays, and hospital services and consumables
- Emergency hospital administration charges
- Booking fees/hospital booking fees, and/or
- fees to confirm the surgeon or room. [31]

Seven percent (7%) of respondents reported that they were charged a 'deposit' to lock in their surgery on their most recent hospital admission. [32]

The Consumers' Health Forum undertook a self-selected survey in 2018, which found, "An unexpected and highly concerning finding was that some surgeons are asking consumers to pay upfront before surgery. Consumers described experiences of being told that they would not be able to proceed with their appointment or with surgery unless they were able to pay up front."[33]

The Australian Competition and Consumer Commission (ACCC) does not explicitly address split billing or balance billing, but does state, "If you promote a price that is only **part of the total price**, the total price must also be displayed at least as prominently as the partial price" and "It is illegal for a business to make claims to customers about its goods or services — including claims about price — that are incorrect or likely to create a false impression."[34]

The Minister's Committee on out of pocket costs "expressed strong concerns about the practice, by an unknown number of medical specialists, of charging 'hidden' administrative or booking fees, which are not disclosed to Medicare or private health insurers and circumvent the requirements of the 'no' or 'known' gap private health insurance arrangements. The Committee was of the view that all charges from a given provider, for an admitted clinical episode, should be provided on a single bill."[35]

The Australian Medical Association has also clearly stated, "A single episode of care or medical service should not be subject to a booking fee or a split bill."[36]

The experience from the United States

Surprise billing has been a policy focus of consumer groups and governments in the United States for a number of years. 33 States have enacted legislation to address surprise billing as at February 2021,[37] and bipartisan legislation, the No Surprises Act, was agreed by Congress in December 2020.[38] [39]

The legislation follows action by the previous US President, Donald Trump, who announced principles to address surprise billing in May 2019[40], followed by an Executive Order in June 2019 with a range of policy proposals to eliminate unnecessary barriers to price and quality transparency; to increase the availability of meaningful price and quality information for patients; to enhance patients' control over their own healthcare resources, ... and to protect patients from surprise medical bills. [41]

The Commonwealth Fund, a world-renowned policy think tank, describes a comprehensive approach to surprise billing legislation as including, among other things, protecting consumers both by "holding them harmless from" extra provider charges (meaning they don't have to pay) and prohibiting providers from balance billing. In states that have adopted both approaches, out-of-network (uncontracted) providers are directly prohibited from balance billing consumers for additional charges beyond what the health plan pays.[42]

In the Australian context, the health plan equivalent is Medicare plus health insurance rebates. The Australian equivalent to a hold harmless provision would be that the patient would not be liable for more than the MBS fee or fund contracted amount without an explicit agreement beforehand.

Policy proposal

Unlike most parts of the economy, "in health care, normal market forces have failed to prevent surprise medical bills."[43]

Surprise billing does not serve the interests of payers (individuals, governments and health funds). There is a strong public value argument for transparency, as it is only with transparency on pricing that we can make informed decisions and ensure efficient allocation of resources.

As surprise billing is only enabled by the strict regulatory environments around health care markets, the options are to deregulate all pricing (including abolishing Medicare) or to introduce a proper regulatory framework for transparent pricing.

Private Healthcare Australia (PHA) recommends:

- Legislation change to ensure consumers not held liable for costs not disclosed beforehand, and
- A criminal offence be introduced for split billing.

No liability for excess costs not disclosed beforehand

For non-emergency admissions, doctors, hospitals and health funds should be able to disclose costs beforehand.

PHA recommends legislation be introduced to protect consumers by ensuring that consumers are not liable for out of pocket costs that have not be disclosed at least seven days in advance of a non-emergency procedure, or two days after booking the procedure in cases where the procedure is booked within the seven day period.

Health funds must disclose all fees and excess amounts under existing legislation.

Hospitals will need to provide information about fees through the booking medical practitioner or directly to the consumer. Should hospitals fail to do so, they will still receive either the amount contracted by the health fund, or if there is no contract with the fund in place, the second-tier default benefit.

All medical practitioners involved in the consumer's care will need to disclose fees to the patient for the expected services. This may be coordinated through the admitting doctor, the hospital or individually. Should a doctor fail to provide a written quote prior to service, they will receive any fee contracted under a no-gap arrangement with the health fund, or where no agreement exists, they will receive the MBS Schedule fee.

Offence to not disclose costs

PHA recommends that legislation be introduced to protect consumers by making it an offence to fail to detail the full cost of a service covered by Medicare or by private health insurance to payers.

One mechanism would be to amend the *Private Health Insurance Act 2007* to introduce an offense if any tax invoice for a service under a private health insurance arrangement (as defined in schedule one) does not include the full cost of the service, referring to the principles of the *Australian Consumer Law 2010*. An explicit clause may be required to prevent split billing or balance billing.

Constitutional issues

The Australian Constitution prohibits the "civil conscription" of doctors,[44] which has been widely interpreted as prohibiting the government regulating medical fees. The limits of this provision have not been fully tested in the High Court, although civil conscription has been debated in other contexts.[45]

PHA contends that our recommendations do not prohibit doctors from setting their own fees in a private contract with the patient but concede the enforcement of such contracting would be made conditional on providing informed financial consent.

Third party positions

PHA's recommendations provide a lesser standard than recommended by Minister's Committee on out of pocket costs, which "was strongly of the view that patients need better fee information before [the] first consultation, noting that such information is complex and has limitations when provided outside of a formal clinical consultation." [46]

The Consumers' Health Forum is "urging the Government and the medical profession to introduce a national standard for informed financial consent requiring patients to be given a single quote covering all components of care, including procedure and diagnostic costs, before operations."[47]

The Australian Medical Association (AMA) "opposes the introduction of any legislation that prescribes or restricts the fees that medical practitioners must charge."[48] However, the recommended position is entirely consistent with the AMA's position statement *Setting Medical Fees and Billing Practices 2017*[49] and *Informed Financial Consent: a collaboration between doctors and patients 2020*.[50]

The Australian Private Hospitals Association "unequivocally endorses transparency in relation to medical fees and out-of-pocket charges including the provision of written information to consumers prior to treatment."[51]

References

[1] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[2] Parliament of Australia 1901, Commonwealth of Australia Constitution Act. Compilation prepared on 4 September 2013 taking into account alterations up to Act No. 84 of 1977, s51(xxiiiA). Available at https://www.legislation.gov.au/Details/C2013Q00005.
[3] Australian Prudential Regulatory Authority 2021, *Quarterly Private Health Insurance Statistics*, March 2021, Available at https://www.apra.gov.au/sites/default/files/2021-05/Quarterly%20private%20health%20insurance%20statistics%20March%202021.pdf
[4] Duckett S, Nemet K 2019. *Saving private health 1: reining in hospital costs and specialist bills*. Grattan Institute. Available at https://grattan.edu.au/wp-content/uploads/2019/11/925-Saving-private-health-1.pdf.
[5] Australian Medical Association (AMA) 2020, 'Informed financial consent: a collaboration between doctors and patients', Last updated September 2020, Available at https://ama.com.au/article/ama-informed-financial-consent
[6] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[7] Australian Medical Association (AMA) 2019, 'Informed financial consent: a collaboration between doctors and patients', Last updated June 2019, Available at https://ama.com.au/article/ama-informed-financial-consent
[8] AMA 2017, 'Setting Medical Fees and Billing Practices 2017' Position statement. Available at https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017.
[9] Australian Institute of Health and Welfare 2019. *Admitted patient care 2017–18: Australian hospital statistics*. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.
[10] Australian Institute of Health and Welfare 2019. *Admitted patient care 2017–18: Australian hospital statistics*. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW. For example, see table 8.6 (onset during care); tables 4.9, 4.10, 4.12, 6.11 (complications) and table 8.9 (falls).
[11] IPSOS 2019. *Medical out of pocket: final report*. March.
[12] IPSOS 2019. *Medical out of pocket: final report*. March.
[13] IPSOS 2019. *Medical out of pocket: final report*. March.
[14] IPSOS 2019. *Medical out of pocket: final report*. March.
[15] Australian Government Department of Health 2018, *Annual Medicare Statistics*, Available at https://www.health.gov.au/internet/main/publishing.nsf/Content/AnnualMedicare-Statistics .
[16] AMA 2017, 'Setting Medical Fees and Billing Practices 2017' Position statement. Available at https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017.
[17] Harris B, Craike M, Dunkin R, Calder R 2019. Is Medicare Fair? iii. Out of pocket costs under Medicare across Australia. Mitchell Institute Policy issues paper no.4-2019, Victoria University. Melbourne. Available at http://www.mitchellinstitute.org.au/wp-content/uploads/2019/11/Is-Medicare-Fair-iii-out-of-pocket-costs.pdf.
[18] Australian Prudential Regulatory Authority (APRA) 2019, 'Quarterly Private Health Insurance Statistics: private health insurance medical gap', Table T1. Available at https://www.apra.gov.au/quarterly-private-health-insurance-statistics. Health funds are required to pay up to the MBS Schedule Fee for medical services. The figure of $373 million was derived by calculating the MBS fee from the MBS benefit ($782 million/75%x100%) then deducing the 25% of the MBS fee required by law from the total fund benefits paid ($634 million).
[19] AMA 2017, 'Setting Medical Fees and Billing Practices 2017' Position statement. Available at https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017
[20] Duckett S, Nemet K 2019. *Saving private health 1: reining in hospital costs and specialist bills*. Grattan Institute. Available at https://grattan.edu.au/wp-content/uploads/2019/11/925-Saving-private-health-1.pdf.
[21] Australian Prudential Regulatory Authority (APRA) 2019, 'Quarterly Private Health Insurance Statistics: private health insurance medical gap.' Available at https://www.apra.gov.au/quarterly-private-health-insurance-statistics.
[22] IPSOS 2019. *Medical out of pocket: final report*. March.
[23] Consumers' Health Forum 2018, Out of pocket pain: research report. Canberra. Available at https://chf.org.au/sites/default/files/20180404_oop_report.pdf.
[24] Department of Health 2020. *Private Hospital Data Bureau Annual Report 2018-19*, Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-PHDBAnnualReports.
[25] Department of Health 2020. *Hospital Casemix Protocol Annual Report 2018-19*, Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports.
[26] Department of Health 2020. *Hospital Casemix Protocol Annual Report 2018-19*, Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports. The other private hospital figure was derived by dividing the average charge by the average length of day.
[27] Department of Health 2020. *Hospital Casemix Protocol Annual Report 2018-19*, Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-casemix-data-collections-publications-HCPAnnualReports.
[28] IPSOS 2019. *Medical out of pocket: final report*. March.
[29] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[30] IPSOS 2019. *Medical out of pocket: final report*. March.
[31] IPSOS 2019. *Medical out of pocket: final report*. March.
[32] IPSOS 2019. *Medical out of pocket: final report*. March.
[33] Consumers' Health Forum 2018, Out of pocket pain: research report. Canberra. Available at https://chf.org.au/sites/default/files/20180404_oop_report.pdf.

[34] Australian Competition and Consumer Commission (ACCC) 2020, 'Displaying prices', Available at https://www.accc.gov.au/business/pricing-surcharging/displaying-prices.
[35] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[36] Australian Medical Association (AMA) 2020, 'Informed financial consent: a collaboration between doctors and patients', Last updated September 2020, Available at https://ama.com.au/article/ama-informed-financial-consent
[37] The Commonwealth Fund 2021, ''State balance-billing protections", Available at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections
[38] Hoadley J, Lucia K, Fuchs B 2020, "Surprise billing protections: help finally arrives for millions of Americans", The Commonwealth Fund, Available at https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law
[39] US Senate Committee on Health, Education, Labor and Pensions 2020, "Congressional committee leaders announce surprise billing agreement", Press release, Available at https://www.help.senate.gov/chair/newsroom/press/congressional-committee-leaders-announce-surprise-billing-agreement
[40] Donald J. Trump 2019, 'Remarks by President Trump on Ending Surprise Medical Billing', The White House, Washington. Available at https://www.whitehouse.gov/briefings-statements/remarks-president-trump-ending-surprise-medical-billing/
[41] Donald J. Trump 2019, 'Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First', The White House, Washington. Available at https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/
[42] Lucia K, Hoadley J, Williams A 2017. 'Balance Billing by Health Care Providers: Assessing Consumer Protections Across States', Issues Brief, June. The Commonwealth Fund, Available at https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer.
[43] Hyman DA, Ippolito B 2019. 'The Potential Pitfalls of Combating Surprise Billing: comment.' *Regulation*, Fall 45-47.
[44] Parliament of Australia 1901, Commonwealth of Australia Constitution Act. Compilation prepared on 4 September 2013 taking into account alterations up to Act No. 84 of 1977, s51(xxiiiA). Available at https://www.legislation.gov.au/Details/C2013Q00005.
[45] British Medical Association v Commonwealth [1949] HCA 44, General Practitioners Society of Australia v Commonwealth [1980] HCA 30, Alexandra Private Geriatric Hospital Pty Ltd v Commonwealth [1987] HCA 6, Health Insurance Commission v Peverill [1994] HCA 8, Breen v Williams [1996] HCA 57, Wong v Commonwealth; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee No 309 [2009] HCA 3
[46] Ministerial Committee on Out-of-pocket Costs 2018. Report. Canberra, November. Available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/3A14048A458101B0CA258231007767FB/%24File/Report%20-%20Ministerial%20Advisory%20Committee%20on%20Out-of-Pocket%20Costs.pdf.
[47] Wells L 2019. 'Medical Costs Finder a disappointing first step.' Consumers' Health Forum media release, 30 December 2019.
[48] AMA 2017, 'Setting Medical Fees and Billing Practices 2017' Position statement. Available at https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017
[49] AMA 2017, 'Setting Medical Fees and Billing Practices 2017' Position statement. Available at https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017.
[50] Australian Medical Association (AMA) 2020, 'Informed financial consent: a collaboration between doctors and patients', Last updated September 2020, Available at https://ama.com.au/article/ama-informed-financial-consent
[51] Australian Private Hospitals Association (AHPA) 2018, 'MBS Review: surgical assistants' submission 18 October, Available at http://www.apha.org.au/wp-content/uploads/2018/10/APHA-response-Surgical-Assistants.pdf.