

***A VOLUNTARY  
CODE OF PRACTICE FOR  
  
HOSPITAL  
PURCHASER/PROVIDER  
AGREEMENT NEGOTIATIONS  
  
BETWEEN PRIVATE HOSPITALS  
  
AND PRIVATE HEALTH INSURERS***

## **Statement from the Minister for Health and Aged Care**

I am pleased to offer my support for the *Voluntary Code of Practice for Hospital Purchaser-Provider Agreement Negotiations between Private Hospitals and Private Health Insurers* (the 'Code').


One of the issues which I consider a priority as Minister with responsibility for private health, is that of increased competition in the private health sector. This is important to support and retain a productive, competitive and viable private health industry.

I support the objective of this Code which aims to improve the efficiency of business arrangements between health funds, private hospitals and day hospital facilities. This Code will maintain confidence in the private health industry by ensuring that contract negotiations between health funds and hospitals are conducted in a fair and reasonable manner.

This Government is committed to industry self-regulation and I therefore applaud this industry initiative regarding agreement on appropriate contracting behaviour. This Code is a

voluntary Code which means that health funds and private hospitals/day hospital facilities are free to determine whether they become signatories to the Code and its conditions. As the Code sets out standards of conduct for the activities of health funds and hospitals when engaged in negotiating the purchasing arrangements pertaining to private health services, I strongly recommend funds and hospitals sign up to the Code. Furthermore, it is commercial common sense for private hospitals/day hospital facilities and health funds to promote themselves through explicit compliance with this Code.

I commend this Code and trust that it will contribute to real changes to the benefit of consumers, providers and purchasers of private health services.



Dr Michael Wooldridge

**JOINT STATEMENT FROM THE  
AUSTRALIAN PRIVATE HOSPITALS  
ASSOCIATION AND THE AUSTRALIAN HEALTH  
INSURANCE ASSOCIATION**

The Australian Private Hospitals Association and the Australian health Insurance Association have reached agreement on this Voluntary Code of Practice for Hospital Purchaser/Provider Agreement Negotiations between Private Hospitals and Private Health Insurers.

The Code is designed to encourage best practice in contacting and is principally concerned with the negotiation process. This includes ensuring the content of contracts includes provisions which are in the best interest of the parties.

A principle objective of the Code is to introduce a framework based on principles of fairness and reasonableness in order to minimise disputes. However, the Code includes a detailed independent dispute resolution process with final reference to the Private Health Insurance Ombudsman, where parties have irreconcilable differences in relation to the application of the Code to the negotiation process.

It is hoped the Code will result in the eliminations of any suggestion of inappropriate behaviour by parties in relation to the negotiation, timing and minimum content of contracts.

While acknowledging that no two situations will be identical, the aim of the code is to assist parties develop consistent and appropriate arrangements by providing a structured basis for contract negotiations.

It should also be recognised that this Code is considered a starting point. The Code has an inbuilt review mechanism to ensure it meets changing circumstances should they arise. In this regard, the Code Administration Committee welcomes feedback and input from signatories in relation to

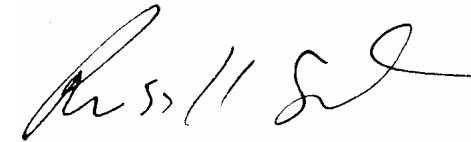
how well the Code meets its objectives in the day to day operating environment.

We commend this Code to all private hospitals and health insurance funds.



Michael Roff  
**EXECUTIVE DIRECTOR**

**AUSTRALIAN PRIVATE HOSPITALS  
ASSOCIATION**



Russell Schneider  
**CHIEF EXECUTIVE OFFICER**

**AUSTRALIAN HEALTH  
INSURANCE ASSOCIATION**

## **BACKGROUND**

1. *This Code was developed by both the private hospitals and health insurance industries to deal with procedural issues affecting the negotiations of contracts between private hospitals and health funds.*
2. *While recognising that contracting between private hospitals and health funds should take place in the context of a competitive market, the Code is designed to establish a framework for the conduct of contract negotiations including principles of mutual obligation and fair and reasonable behaviour by the parties.*
3. *Nothing in the Code should be interpreted as conferring or implying a right of a private hospital or health fund to enter into a hospital purchaser provider agreement (HPPA).*
4. *Parties who choose to become signatories to the Code agree to abide by the provisions of the Code including adherence to the agreed dispute resolution process.*
5. *It is expected that the Code will result in an improved understanding by all signatories of their rights and responsibilities in relation to the contract negotiation process. In addition, adherence to the Code should lead to improved relations between private hospitals and health funds including a better recognition of the interdependency between the two sectors.*
6. *Signatories expect the measures of the success of this Code will include, but not be limited to:*
  - I. *the number of signatories;*
  - II. *the proportion of private hospitals and health funds who become signatories;*
  - III. *the number of HPPA's entered into by signatories during the operation of the Code;*
  - IV. *the relative proportion of current HPPA's;*
  - V. *the number of disputes referred to the dispute resolution process specified in the Code; and*
  - VI. *the proportion of disputes successfully resolved under the dispute resolution process specified in the Code.*

## 1. **Terminology**

1.1. In this Code the terms:

**'Committee'** means the Code Administration Committee established under this Code.

**'Contract'** means a Hospital Purchaser Provider Agreement.

**'Health insurer'** means a registered health benefits organisation or other purchaser of health care services, which is a signatory to this Code.

**'Hospital'** means a hospital, a day hospital facility, or a hospital group which is a signatory to this Code and which has been declared by the Minister for Health and Aged Care to be a hospital for the purposes of the *Health Insurance Act 1973 and the National Health Act 1953*.

**'Hospital Group'** means an entity which is comprised of more than one hospital, or has authority to contract on behalf of one or more hospitals.

**'Ombudsman'** means the Private Health Insurance Ombudsman.

**'Negotiation Agent'** means a person or organisation vested with appropriate authority, acting on behalf of an individual hospital, hospital group or health insurer.<sup>1</sup>

## 2. **Aims**

2.1. This voluntary Code of Practice seeks to:

2.1.1. Describe the responsibilities and mutual obligations which should apply between hospitals and health insurers in contract negotiations.

2.1.2. improve relations between hospitals and health insurers through appropriate

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<sup>1</sup> The principle is accepted that agents can act for both hospitals or insurers in negotiating HPPAs and therefore should be bound by Code standards. However, individual signatories (hospitals or corporate hospital groups or individual funds) are primarily responsible for meeting their own obligations under the Code.

disclosure of information by all parties during contract negotiations.

2.1.3. facilitate the negotiation of contracts which are considered to be fair and reasonable by both hospitals and health insurers.

2.1.4. introduce a framework based on principles of fairness and reasonableness in order to minimise disputes.

### **3. *Accession to the Code***

3.1. A hospital, hospital group or health insurer may become a signatory to this Code by written notification to the Committee and payment of the prescribed administration fee as determined by the Committee.<sup>2</sup>

3.2. A signatory may cease to be a signatory to this Code by written notification to the Committee.

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<sup>2</sup> In principle, it is expected that the industries are expected to meet the costs on a 50/50 basis. Pending sufficient sign up, hospitals and insurers will meet their own costs.

3.3. Such notification will become effective upon its receipt by the Committee or on a date specified in the notification.

3.4. Following a period of 12 months of the Code's operation representatives of the Code Administration Committee will meet to consider its appropriateness and acceptability, and within 3 months identify any mutually agreed deficiencies, and recommend amendments<sup>3</sup>. If the parties cannot agree, the Code lapses within 18 months of commencement unless the Code Administration Committee allows extensions of up to three months at a time, to continue negotiations on a review of the Code.

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<sup>3</sup> This does not remove the right for a signatory to withdraw from the Code at any time.

#### **4. *Obligations of Signatories to the Code***

- 4.1. The Code applies to each hospital, hospital group or health insurer, that is a signatory to this Code.
- 4.2. An organisation notifying the Committee that it wishes to accede to the Code agrees to be bound by both the spirit and letter of the Code, including any revisions made in accordance with clause 3.4 This Code applies to the employees of signatory organisations and negotiations agents acting on behalf of signatories.
- 4.3. No adverse inference should be drawn from the withdrawal of any signatory.
- 4.4. A signatory may cease to be a party to the Code at any time by notifying the Committee
- 4.5. Each signatory agrees to endeavour in good faith to resolve disputes about matters covered by the Code between itself and any other signatory or signatories through the dispute resolution

mechanisms of the Code but the Code's dispute resolution mechanisms do not replace dispute resolution mechanisms or any other matter<sup>4</sup> specified in current contracts, prior to the commencement of the Code.

- 4.6. Where an executed contract and the Code conflict the contract shall prevail.
- 4.7. The Code does not cover the level of benefits or prices to apply in contracts.

#### **5. *Core Principles***

- 5.1. Signatories to the Code acknowledge that private hospitals compete on their own merits for contracts. There is no obligation on health insurers to offer contracts to all private hospitals and there is no obligation on a hospital to accept a contract.
- 5.2. Signatories acknowledge that health insurers have the right to sell products to consumers offering

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<sup>4</sup> This is intended to make it clear that the code applies to the negotiating process, but does not override a contractual agreement.

various levels of cover in a range of hospitals.

Health insurers should demonstrate that contracted hospital selection processes are fair and reasonable.

5.3. Signatories acknowledge that there are many ways in which health insurers and hospitals may wish to negotiate contracts, including, but not limited to selective tendering arrangements.

5.4. Where a health insurer chooses to implement selective or restrictive contracting in a market defined geographically or by the specific services to be purchased, all private hospitals operating in the relevant market must be invited to submit a tender, or to directly negotiate, for the provision of the required services. Such an invitation should take the form of a letter to each relevant hospital and a prominently displayed advertisement in a major newspaper in the relevant region.

5.5. Health insurers must ensure that processes used for selection of hospitals are equitable and transparent including meeting the following criteria:

5.5.1. All materially relevant information (*ie that information which comprises selection criteria or anything that alters previously advised selection criteria*) to the performance of the proposed contract, must be identified. This does not preclude a hospital from adding innovative inclusions in its tender, and any acceptance by the fund does not infringe the Code.

5.5.2. timeframes must be clearly specified in all 'invitation to tender' and/or other relevant notices and documents;

5.5.3. where additional specifications or information are added after the original specifications have been issued, this information must be provided by the health



insurer to all hospitals that were provided with the original specifications; and

- 5.5.4. health insurers must ensure that timeframes are clearly specified in any documentation and all materially relevant information to the performance of the proposed contract is disclosed in a reasonable period before the commencement of negotiation.

5.6. Where an insurer declines to contract with a signatory hospital in any specific market, such hospitals must be notified in writing of this decision, including the general reasons for not obtaining a contract, wherever possible no later than thirty days before the date of contract commencement in the relevant market or such lesser period as may be reasonable under the circumstances.<sup>5</sup>

5.7. Signatories acknowledge that hospitals may, for a variety of reasons, wish to enter only into contracts with particular insurers. Hospitals must also demonstrate that their selection processes are fair and reasonable.

5.8. If a hospital wishes to offer its services on a selective basis it must inform all health funds

operating in the relevant market of its intentions and invite them to seek further information or submit a tender as appropriate.

5.9. Where a hospital declines to contract with a signatory insurer in any specific market, such insurers must be notified in writing of this decision, including the general reasons for not obtaining a contract, wherever possible no later than thirty days before the date of contract commencement in the relevant market or such lesser period as may be reasonable in the relevant market or such lesser period as may be reasonable under the circumstances.<sup>6</sup>

5.10. In the event that one party does not wish to recommence or continue negotiations they must inform the other party as soon as practical.

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<sup>5</sup> It is expected that there would have to be exceptional circumstances for less than 30 days advance notice to be provided.

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<sup>6</sup> It is expected that there would have to be exceptional circumstances for less than 30 days advance notice to be provided.

## **6. Accuracy of Information**

6.1. Health insurers and hospitals must ensure to the best of their endeavours that all information provided to the other party is accurate, timely and complete.

## **7. Negotiation Agents**

7.1. Health insurers and hospitals may nominate contract negotiation agents. All persons appointed as negotiation agents, for the purpose of acting on behalf of either a fund or hospital must be vested with appropriate authority and be identified in writing to the other party. Negotiation agents acting on behalf of several hospitals or health funds must retain the confidentiality of separate negotiations, consistent with the requirements of the *Trade Practices Act*. An agent should, at the outset of any negotiation, advise the other party as to which organisations or individuals they may also represent, and if this changes at any time.

## **8. Contract Content**

8.1. Unless otherwise agreed proposed contracts being negotiated between hospitals and health insurers should<sup>7</sup> include provisions that cover:

8.1.1. time frames, including but not limited to, if renegotiation is going to take place, a date by which renegotiation for a replacement contract must commence<sup>8</sup>; a date for the finalisation of a replacement contract, which should be a date not later than the date of the existing contract expiry; and the period of notice, during contract negotiation or renegotiation, which must be provided

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<sup>7</sup> While one would expect these items to be logically included in a contract, funds and hospitals may find it mutually advantageous to exclude them or deal with them in different ways. The key is the term "agreed" which should be taken literally: i.e., it would be unreasonable for a fund or a hospital to refuse to include such provisions in a contract. It would not be unreasonable for them to disagree on the actual terms: e.g., whether a time period should be 7 days or weeks, etc, although one would expect such periods to generally apply for all parties in the same arrangements for price, performance, etc.

<sup>8</sup> A recommended time frame is 3 months prior to expiry.

- for either party to respond to contract proposals<sup>9</sup>;
- 8.1.2. efficiency and customer focus issues, including processes for the provision to patients of an estimate of any out-of-pocket expenses that may be charged to the patient as a result of health insurance benefits not meeting hospital charges;
  - 8.1.3. all relevant prices and fees;
  - 8.1.4. roles and responsibilities of both parties;
  - 8.1.5. legally binding transitional financial arrangements, to apply when an existing contract expires and while renegotiation of a replacement contract continues;
  - 8.1.6. termination arrangements, for example, the period of written notice each party must provide where a contract is not to be renewed; financial arrangements in respect of pre-booked admissions affected by a

- contract termination; the method of communication of termination arrangements to members and patients, information to be provided to patients on any additional out of pocket expenses as a result of the termination; and
- 8.1.7. dispute resolution/mediation processes to apply during the operation of the contract.

## **9. Confidentiality**

- 9.1. Contracts should include a confidentiality clause. However, where a dispute is referred to the Ombudsman pursuant to the Code, the parties must provide the Ombudsman with such information as necessary to assist him/her to resolve the dispute.
- 9.2. All patient information must remain confidential, consistent with the *National Principles for the Fair Handling of Personal Information*.

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<sup>9</sup> A recommended time frame is 14 days.

rendering of professional services to which the agreement applies.

## **10. Acceptance of Standard Classification Systems**

10.1. Standard national classification systems (including the Commonwealth Medical Benefits Schedule, AN-DRG's, ICD-10AM, the Patient Classification system for accommodation benefits, the Procedure Banding List and the National Health Data Dictionary) and such other systems as agreed by the parties to this Code, shall be the basis for determining relevant contractual benefits.

## **11. Protection of Clinical Discretion**

11.1. The parties acknowledge that while allowing for the development, promotion, and adoption of clinical guidelines and pathways, together with evidence based medicine protocols, contracts must require signatories to maintain the medical practitioner's freedom within the scope of accepted clinical practice to identify appropriate treatments in the

## **12. Quality Service Indicators**

- 12.1. If quality indicators are to be used in a contract, hospitals and health insurers should agree on the appropriateness of those indicators and how they are to be used.
- 12.2. Such agreed quality indicators should be transparent, easily understood, capable of objective measurement, and applied consistently.
- 12.3. Health insurers should be able to reward quality.

### **13. Substantial Service Changes**

- 13.1. Contracts should contain a clause specifying a reasonable notice period should hospitals wish to make substantial changes to services that may have an impact on costs to health insurers.<sup>10</sup>
- 13.2. Contracts should contain a clause outlining the process by which insurers will review hospital submissions for new or changed services. While approval of such submissions should not be unreasonably withheld hospitals should not automatically assume increased benefits for such services.
- 13.3. Proposed contract amendments, which vary the services purchased by insurers, must be made in writing and agreed by both parties.

### **14. Amendments to Benefits Payable**

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<sup>10</sup> This code does not attempt to define “substantial”. It is expected that the parties will determine what issues or quantum may be “substantial” during the negotiations.

- 14.1. Contracts should contain a clause specifying a reasonable notice period should insurers wish to make changes to benefits paid during a contract term to hospitals.
- 14.2. Proposed contract amendments, which vary the benefits payable to a hospital, must be made in writing and agreed by both parties

### **15. Data Standard**

- 15.1 Unless otherwise agreed contracts must specify that billing and payment systems data requirements are limited to the Hospital Casemix Protocol extended data set.

### **16. Communication to Health Fund Members**

- 16.1. Health insurers must keep their members informed of changes to contracted hospital arrangements and of any changes to benefit levels in a

reasonably timely manner in accordance with the insurers normal communication systems.

- 16.2. Outcomes of contract negotiations must be communicated to patients affected by the changes in a fair and reasonable manner and in a way that avoids adverse publicity or negative perceptions of either specific insurers or hospitals.

## **17. *Dispute Resolution During Contract Operation***

- 17.1. A dispute resolution mechanism clause must be included in all contracts. Such a clause must cover disputes regarding interpretation of a contract during the course of that contract.

## **18. *Code Administration Committee***

- 18.1. This Code is to be administered by a Code Administration Committee, comprising two

nominees of the Australian Private Hospitals Association, one nominee of Catholic Health Australia and three nominees of the Australian Health Insurance Association. The chair of the Committee shall rotate at each meeting.

- 18.2. All decisions of the Committee must be made by consensus, other than those relating to clause 21.

## **19. *Role of the Code Administration Committee***

- 19.1. The role of the Committee is to:

- 19.1.1. monitor the operation of the Code;
- 19.1.2. determine adequate funding for the administration of the scheme;
- 19.1.3. provide for publicity and education programs to hospitals and insurers as required;
- 19.1.4. determine a complaint lodgement fee for the dispute resolution process;

- 19.1.5. maintain a register of signatories to the Code;
- 19.1.6. consider recommendations from the Ombudsman in accordance with the provisions of clause 21;
- 19.1.7. advise all signatories of any changes to signatories of the Code including new signatories, withdrawals and expulsions; and
- 19.1.8. consider extensions to the operation of the Code in accordance with clause 3.4.

## **20. *Dispute Resolution During Contract Negotiations***

- 20.1. Where a dispute arises involving an alleged breach of the Code between a hospital and a health insurer, the parties must undertake the following steps:
- 20.1.1. the complainant must raise the matter in writing with the other party, setting out the

background and issues in dispute, including, where appropriate, the grounds on which the complainant believes the Code has been breached and the remedy or outcome desired. The respondent party must reply in writing within 14 days. The parties must make every effort to resolve the dispute in good faith;

- 20.1.2. if a dispute cannot be resolved to the satisfaction of the parties in accordance with sub-clause 20.1.1, the matter may be referred to the Ombudsman by either of the parties, subject to the referring party paying the prescribed lodgement fee and providing written notice to the Code Administration Committee.

## **21. *Role of the Ombudsman***

- 21.1. The Ombudsman will act as an independent mediator on disputes and have power to



recommend to the parties actions to be taken to resolve the dispute.

21.2. If either party refuses to act on the Ombudsman's recommendations the Ombudsman would have the power to recommend to the Code Administration Committee that the party be suspended (for a defined period) or expelled from the Code.

21.3. The Code Administration Committee must give effect to the Ombudsman's recommendation for suspension or expulsion unless a majority of the Committee decides otherwise.

21.4. Nothing in this Clause prevents disputing parties from resolving the matter at any time up to the Code Administration Committee making its decision pursuant to clause 21.3.

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## **ATTACHMENT 1**

### **CODE ADMINISTRATION COMMITTEE**

#### **TERMS OF REFERENCE**

1. The Code Administration Committee (the Committee) will comprise six (6) members in accordance with clause 18.1 of the Code.
2. The Committee shall perform its role as defined in clause 19 of the Code.
3. The Committee shall meet as required but not less than 3 times per 12 month period measured from the commencement of the Code.
4. Meetings shall be held in person or by other means as deemed appropriate by the Committee.
5. Attendance and maintenance of 4 members of the Committee shall constitute a quorum. Where a meeting falls below the quorum the meeting shall be adjourned until a quorum can be obtained.
6. Notwithstanding term 4, a quorum cannot be declared unless at least 2 of the attending Committee members are representatives of health insurers and 2 are representatives of private hospitals.

7. Each member of the Committee shall have an equal vote regardless of whether they hold the position of Chairman for the purposes of that meeting.
8. In the event of a potential conflict of interest, the nominating organisations (APHA, CHA, AHIA) can nominate an alternate to take part in Committee meetings as required.
9. Decisions of the Committee will be made in accordance with Clause 18.2 of the Code.

## **ATTACHMENT 2**

### **DISPUTE RESOLUTION PROCESS**

1. In dealing with matters under this Code the Private Health Insurance Ombudsman (the Ombudsman) can only consider disputes in relation to alleged breaches of the Code of Practice.
2. The parties must undertake to resolve any dispute in accordance with the provisions of clause 20 of the Code before a dispute can be referred to the Ombudsman.
3. Where a signatory to the Code wishes to refer a dispute to the Ombudsman, they must notify the Ombudsman in writing and include the following information:
  - the grounds on which the complainant alleges the Code has been breached;
  - the desired remedy or outcome; and
  - efforts undertaken by the parties to resolve the dispute prior to reference to the Ombudsman.
4. The Ombudsman will not determine the background to a dispute. Rather, the Ombudsman will consider if the dispute as presented constitutes a breach of the Code and identify mechanisms to nullify the breach.

5. The Ombudsman may, without reference to the respondent, determine that a dispute as presented by the complainant does not constitute a breach of the Code and that no further action is necessary.
6. The Ombudsman may take such action as he deems necessary to resolve the dispute, including, but not limited to, requesting information from either party or convening a meeting of the parties.
7. The parties may only represent themselves at a meeting convened by the Ombudsman. However, parties may choose to be assisted at such meetings by a representative of their relevant industry association (i.e. AHIA, APHA or CHA)
8. The Ombudsman will seek to achieve a mediated resolution to the dispute. Where this is not possible the Ombudsman may recommend to the parties actions to be taken to resolve the dispute.
9. If a party or parties do not act on the Ombudsman's recommendations, the Ombudsman may recommend sanctions against that party or parties in accordance with the provisions of clause 21 of the Code.
10. Where the Ombudsman intends to recommend sanctions against a party or parties, he must advise the party or parties of that intent prior to submitting a recommendation to the Code Administration Committee.