Annual Report 2018–19

Independent Hospital Pricing Authority

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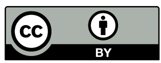

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Letter of transmittal

IHPA

The Hon Greg Hunt
Minister for Health
Parliament House
CANBERRA ACT 2600

Dear Minister,

In accordance with the requirements of the *National Health Reform Act 2011* and the *Public Governance, Performance and Accountability Act 2013*, I am pleased to submit to you, for presentation to Parliament, the annual report and financial statements of the Independent Hospital Pricing Authority (IHPA) for the financial year ended 30 June 2019.

The Annual Report 2018-19 reflects the Requirement for Annual Reports approved by the Joint Committee of Public Accounts and Audit under section 63 and 70 of the *Public Service Act 1999* and includes IHPA's audited Financial Statements as required by the *Public Governance, Performance and Accountability Act 2013*.

Yours sincerely,

James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

12 . September 2019

Independent Hospital Pricing Authority

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Approval by the accountable authority

I present the annual report of the Independent Hospital Pricing Authority for the financial year ended 30 June 2019, in accordance with the *National Health Reform Act 2011* and pursuant to section 46 of the *Public Governance, Performance and Accountability Act 2013.*

The Independent Hospital Pricing Authority is a corporate Commonwealth entity. This report has been prepared in accordance with the requirements of sections 17BA to 17BF of the Public Governance, Performance and Accountability Rule 2014. This report also contains information required under other applicable legislation, including the *Work Health and Safety Act 2011*.

As the accountable authority for the purposes of the *Public Governance, Performance and Accountability Act 2013*, I am responsible for preparing this annual report and providing a copy to the responsible Minister.

James Downie

Chief Executive Officer
Independent Hospital Pricing Authority
12 September 2019

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About IHPA

Legislation

The Independent Hospital Pricing Authority (IHPA) is a corporate Commonwealth entity under the *Public Governance, Performance and Accountability Act 2013*.

National Health Reform Agreement

IHPA was established under the *National Health Reform Act 2011*, giving effect to the National Health Reform Agreement signed by the Australian Government and all states and territories in August 2011.

The National Health Reform Agreement sets out the intention of all Australian governments to work in partnership to improve health outcomes for all Australians.

Addendum to the National Health Reform Agreement

In 2017, all Australian governments signed the Addendum to the National Health Reform Agreement.

The Addendum preserves important parts of the existing hospital funding system, including activity based funding. It also focuses on reducing unnecessary hospitalisations and improving patient safety and service quality.

Under the Addendum, IHPA is required to advise on options for a comprehensive and risk-adjusted model to determine how funding and pricing could be used to improve health outcomes for patients and decrease avoidable demand for public hospital services.

The National Health Reform Agreement sets out the intention of all Australian governments to work in partnership to improve health outcomes for all Australians.

Who we are

The Independent Hospital Pricing Authority (IHPA) is an independent government agency established by the Commonwealth as part of the *National Health Reform Act 2011* to contribute to significant reforms to improve Australian public hospitals.

A major component of these reforms is the implementation of national activity based funding for Australian public hospital services.

Vision

To design pricing systems that promote safe, efficient public hospital care for all Australians.

Purpose

To promote improved efficiency in, and access to, safe and high-quality public hospital services, primarily through setting National Efficient Price and levels of block funding for public hospital activities.

Organisational values

IHPA's organisational values shape the culture of the organisation and form the basis for stakeholder engagement to achieve its vision. Our core values are as follows:

- We act with independence, transparency, fairness, respect, accuracy, and accountability.
- We value collaboration, and demonstrate our values in the way we interact internally, and with our stakeholders and the broader community.
- We value the work, talent and contribution of our staff and create organisation-wide development strategies to maintain and grow expertise and intellectual capital.
- Our staff act ethically, support a collaborative culture and take pride in their work.

Functions

Pursuant to the *National Health Reform Act 2011*, the primary functions of IHPA are as follows:

- to determine the National Efficient Price for health care services provided by public hospitals where the services are funded on an activity basis
- to determine the National Efficient Cost for health care services provided by public hospitals where the services are block funded
- to publish the National Efficient Price, National Efficient Cost and other information each year for the purpose of informing decision-makers in relation to the funding of public hospitals.

IHPA was established to promote improved efficiency in, and access to, public hospital services through the provision of independent advice to Australian governments. IHPA achieves this by developing and implementing robust systems to support activity based funding for those services (see **'Pricing for public hospital funding', p7**).

In undertaking its work, IHPA is required to consider the actual cost of delivering public hospital services in as wide a range of hospitals as practicable. It is also required to take into account any legitimate and unavoidable variations in costs due to hospital characteristics and patient complexity. IHPA balances a range of national policy objectives, guided by principles contained in the National Health Reform Agreement and its amendments.

Pricing and funding for safety and quality

Pricing and funding for safety and quality work originated from the April 2016 Council of Australian Governments' Heads of Agreement on Public Hospital Funding.

In 2017, all Australian governments signed an addendum to the National Health Reform Agreement that emphasised a commitment to develop and implement reforms to improve the health outcomes of Australians through funding and pricing for safety and quality.

These pricing and funding approaches intend to complement existing strategies to improve safety and quality in public health care.

Under the Addendum, IHPA is required to advise on options for a comprehensive and risk-adjusted model to determine how funding and pricing could be used to improve patient outcomes across three key areas: sentinel events, hospital acquired complications and avoidable hospital readmissions.

The implementation of pricing and funding for safety and quality has been rolled out in stages as follows:

- **Sentinel events:** Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient.

  Since 1 July 2017, no Commonwealth funding has been provided for any public hospital episode that includes a sentinel event. This policy applies to both activity based and block funded hospitals.

- **Hospital acquired complications:** A hospital acquired complication refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. IHPA has worked with Australian Commission on Safety and Quality in Health Care and other stakeholders to develop an agreed list of hospital acquired complications.

  From 1 July 2018, funding is reduced for any episode of admitted acute care where hospital acquired complications such as falls, infections or pressure injuries occur during a hospital stay.

- **Avoidable readmissions:** Unplanned hospital readmissions are a measure of potential issues with the quality, continuity and integration of care provided to patients during or subsequent to their original hospital stay.

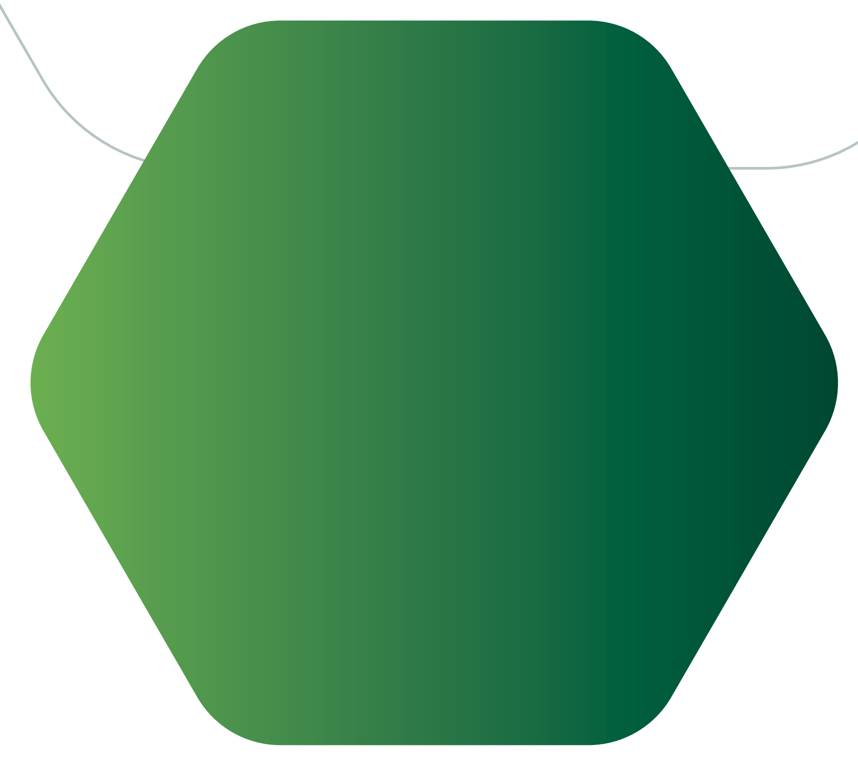
  The Addendum requires that IHPA develop pricing and funding adjustments to target avoidable hospital readmissions, which arise from complications of the management of the patient's original hospital admission.

  From 1 July 2019, IHPA has commenced shadowing funding options for a 24-month period.

Responsible Minister

The Independent Hospital Pricing Authority sits within the Department of Health portfolio.

The Minister responsible for this reporting period is the Hon. Greg Hunt MP, Minister for Health.



Pricing for public hospital funding

Under the National Health Reform Agreement, IHPA was established to contribute to significant reforms to improve the transparency of public hospital funding.

A vital component of these reforms is the implementation of activity based funding for Australian public hospitals.

IHPA designs the pricing systems that underpin the activity based funding approaches.

Each financial year, IHPA releases the annual National Efficient Price and National Efficient Cost Determinations.

These Determinations, in conjunction with data regarding the actual value and type of hospital services provided by states and territories, are used by the Administrator of the National Health Funding Pool to calculate the Commonwealth funding contribution to public hospitals.

National Efficient Price 2019–20

$5,134 Average cost of an episode of care in a public hospital

460

AUSTRALIAN PUBLIC HOSPITALS

receive funding based on their activity levels

Activity based funding

Activity based funding describes the system by which hospitals are paid based on the number and complexity of patients they treat.

If a hospital treats more patients, it receives more funding. This method takes into account the fact that some patients are more complicated to treat than others.

Funding for public hospital services is based on the number of weighted services provided to patients, and the price to be paid for delivering those services.

Activity based funding enables efficiency comparisons to be made between hospitals, and allows system and hospital managers to identify inefficient practices, manage costs and optimise resource allocation. It is a useful tool to measure hospital performance and to establish appropriate benchmarks.

The **National Efficient Price** underpins the implementation of activity based funding.

In 2018–19, national classifications were used to fund the following service categories on an activity basis:

- admitted acute services
- admitted mental health services
- subacute and non–acute services
- emergency department services
- non–admitted services.

The building blocks required for an activity based funding system are discussed below.

Data collection

For activity based funding to be effective, each patient episode needs to be counted. This includes inpatient admissions, emergency department presentations and outpatient appointments, as well as a range of mental health and subacute services.

Classifications

Classifications provide the healthcare sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs to provide better management, measurement and funding of high-quality and efficient health care.

Costing

Hospital costing focuses on the cost and mix of resources used to deliver patient care.

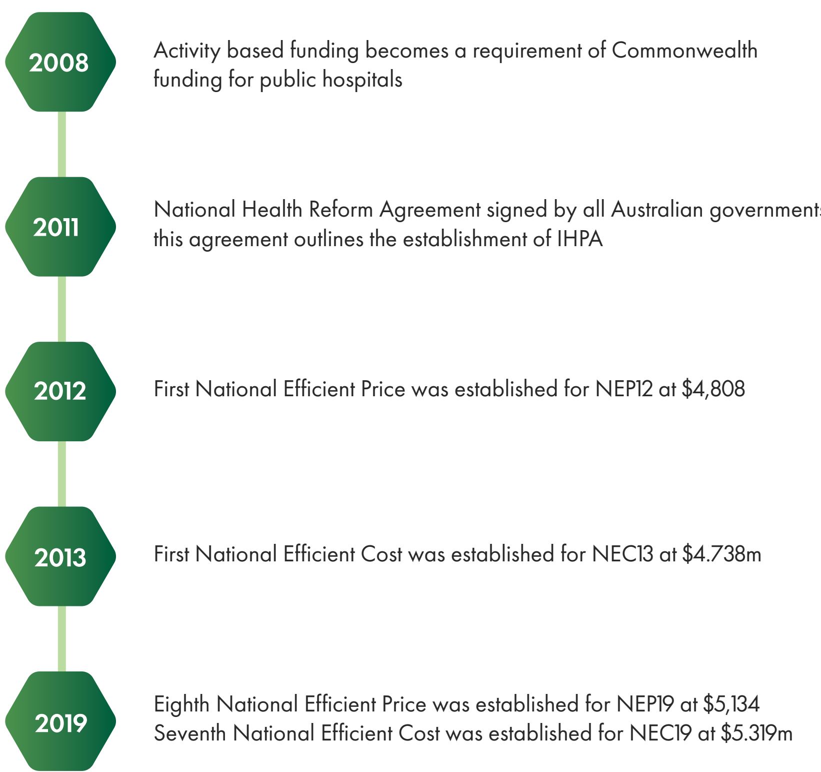
In activity based funding it is essential to understand the total costs involved in the provision of hospital services to a patient, and assign costs based on resource consumption. IHPA collects and reports on the National Hospital Cost Data Collection annually. This information is used for developing the classification systems and for the pricing model.

Pricing

The pricing model determines how much is paid for an average patient. The pricing model adequately recognises factors that increase the cost of care that may not be picked up in the classification system example, the additional cost of providing health services in remote areas, or to children.

Further details of the activity based funding, including its requirements, are available at **www.ihpa.gov.au/what-we-do**.

Activity based funding timeline



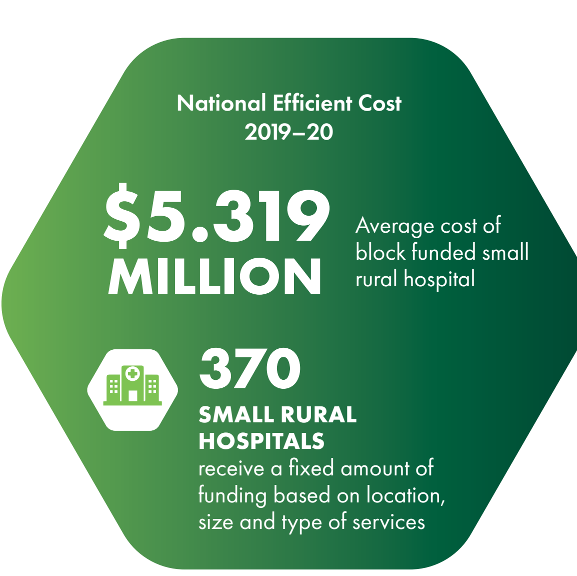
Block funding

The **National Efficient Cost** underpins funding for services that are not suitable for activity based funding, such as:

- small rural and regional hospitals
- teaching, training and research in public hospitals
- non-admitted mental health.

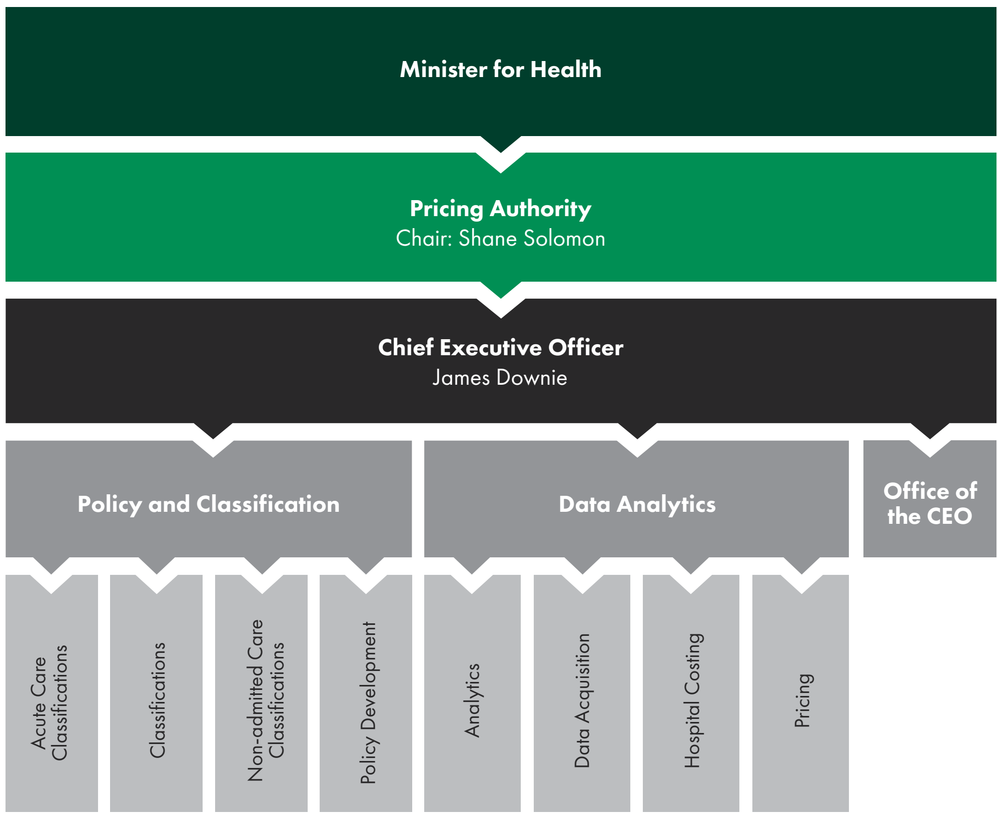
The National Efficient Cost also represents the average cost of Commonwealth funding contribution on a block grant basis for small rural hospitals.

The National Efficient Cost is determined using the in-scope activity and expenditure data for hospitals to be block funded. Hospitals are assigned to a size-locality grouping and mean expenditure is calculated for groupings.



Organisational structure

Figure 1: IHPA's organisational structure as at 30 June 2019



The Pricing Authority is a corporate Commonwealth entity consisting of a Chair, Deputy Chair, and up to seven other members. The Chair of the Pricing Authority reports directly to the Minister for Health. For more information about the Pricing Authority, see **p18**.

The Chief Executive Officer is responsible for the day-to-day management of IHPA and its staff. Under s. 163(4) of the *National Health Reform Act 2011*, the Chief Executive Officer is the accountable authority of IHPA for the purposes of the *Public Governance, Performance and Accountability Act 2013*, and therefore for this annual report.

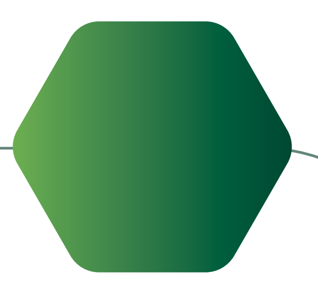
To achieve its annual program of work, IHPA consults and collaborates with the Commonwealth and state and territory governments, advisory committees, key stakeholders and the public.

The IHPA office in Sydney is the only facility of the entity and IHPA's major activities are located there.

Committees and working groups

IHPA has developed a committee framework to assist in providing expert advice and to ensure the transparency and integrity of the organisation.

IHPA's statutory committees comprise the Clinical Advisory Committee and the Jurisdictional Advisory Committee, established under Parts 4.10 and 4.11 of the *National Health Reform Act 2011*.

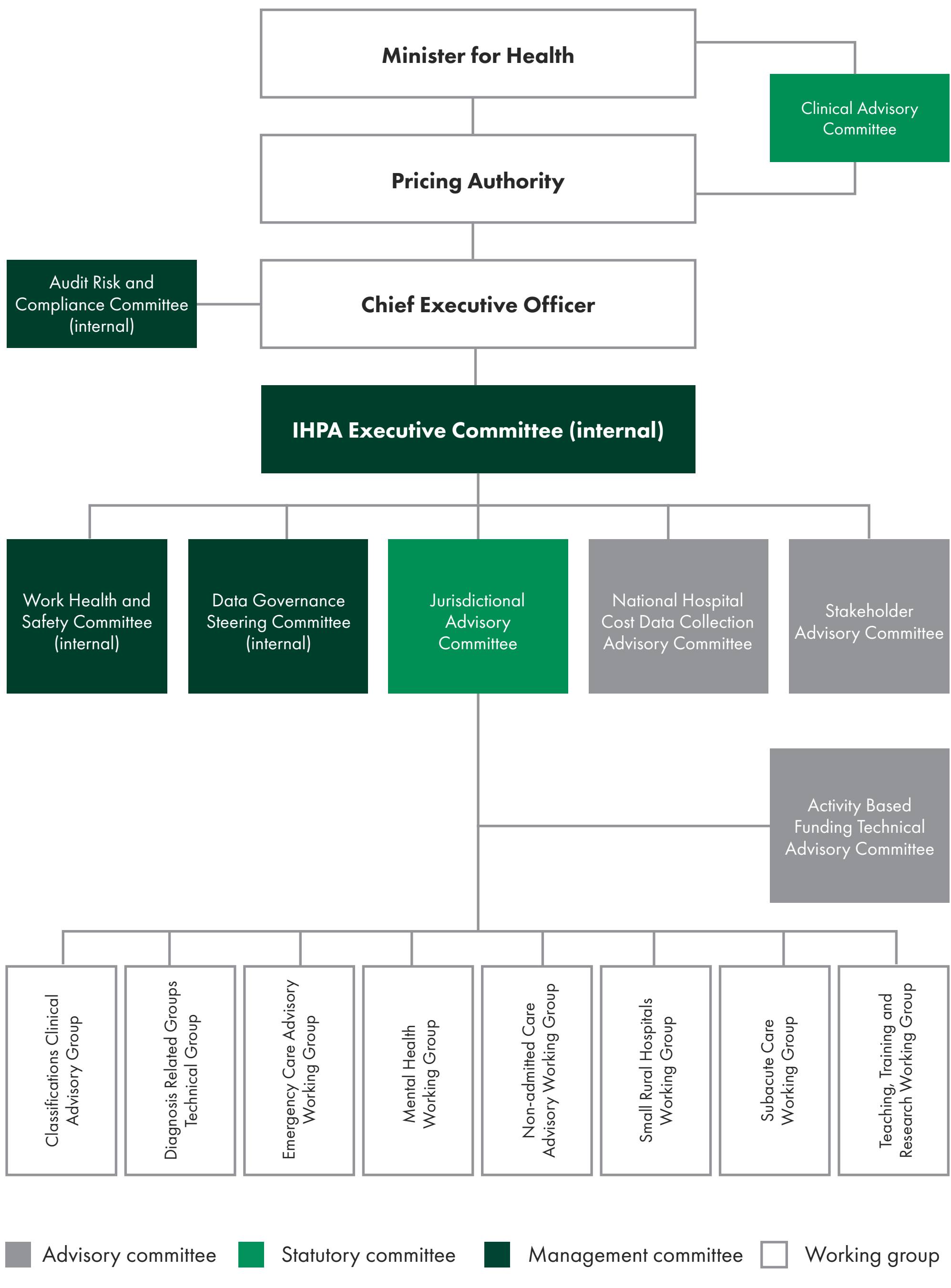


Other advisory committees and working groups have been established to assist IHPA in the delivery of its work program, pursuant to Part 4.12 of the *National Health Reform Act 2011*. These include:

- Activity Based Funding Technical Advisory Committee
- Audit, Risk and Compliance Committee (internal)
- Classifications Clinical Advisory Group
- Data Governance Steering Committee (internal)
- Diagnosis Related Groups Technical Group
- Emergency Care Advisory Working Group
- Mental Health Working Group
- National Hospital Cost Data Collection Advisory Committee
- Non-admitted Care Advisory Working Group
- Small Rural Hospitals Working Group
- Stakeholder Advisory Committee
- Subacute Care Working Group
- Teaching, Training and Research Working Group
- Work Health and Safety Committee (internal)

Committees and working groups are structured to enhance IHPA's statutory functions. Some committees and working groups may also have sub-committees to assist in the delivery of IHPA's work program. All committees and working groups have Terms of Reference setting out their role, function, membership, and reporting relationship.

Figure 2: IHPA's management, committees and working groups



Clinical Advisory Committee

The Clinical Advisory Committee was established under section 176 of the *National Health Reform Act 2011*. Its functions include:

- advising the Pricing Authority on developing and specifying classification systems for health care and other services provided by public hospitals
- advising the Pricing Authority in relation to:
    - matters related to the functions of the Pricing Authority
    - matters referred to it by the Pricing Authority.

Committee members are appointed by the Australian Government Minister for Health. At 30 June 2019, the Clinical Advisory Committee consists of 21 members.

The Clinical Advisory Committee is required to report annually. The Clinical Advisory Committee Annual Report, including details of its members and meetings, sits within the IHPA Annual Report, at **p31**.

Jurisdictional Advisory Committee

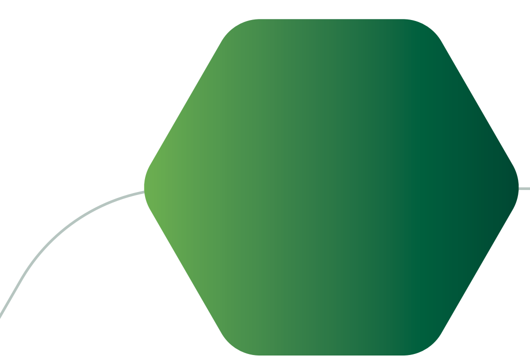
The Jurisdictional Advisory Committee was established under section 195 of the *National Health Reform Act 2011*. It consists of a Chair appointed by the Pricing Authority and nine other members (one to represent each state, territory and the Australian Government). Committee members are appointed by written instrument by the head of the health department of each jurisdiction.

The Jurisdictional Advisory Committee met on 10 occasions between 1 July 2018 and 30 June 2019.

Jurisdictional Advisory Committee members as of 30 June 2019:

- James Downie, Chair
- Rob Anderson (Western Australia)
- Lynne Cowan (South Australia)
- Toni Cunningham (Queensland)
- Karen Doran (Australian Capital Territory)
- Denise Ferrier (Victoria)
- Nigel Lyons (New South Wales)
- Paul McBride (Commonwealth Government)
- Ross Smith (Tasmania)
- Stathi Tsangaris (Northern Territory)

During the reporting period there were changes to the Australian Capital Territory, Commonwealth, Northern Territory and South Australia membership.



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Pricing Authority

Chair's welcome

I am pleased to present the Independent Hospital Pricing Authority's Annual Report for 2018–19.

As Chair of the Pricing Authority, it was a pleasure to lead IHPA last year to deliver another full work program.

In the next pages, you will find some of the many results achieved by IHPA throughout 2018–19. They reinforce IHPA's commitment to delivering sustainable, efficient and safe public hospital services for all Australians.

Delivering safe, high-quality and efficient health care

IHPA continues to incorporate safety and quality into the pricing and funding of public hospital services to improve health outcomes, discourage unnecessary or unsafe care, and decrease avoidable demand for public hospital services.

In partnership with the Australian Commission on Safety and Quality in Health Care and other stakeholders, IHPA undertook extensive work to identify options for incorporating safety and quality into the pricing and funding of public hospital services.

These funding and pricing approaches complement existing measures Australian governments have in place for improving safer care in public hospitals and provide a financial incentive for hospitals to reduce the rate of hospital acquired complications and sentinel events.

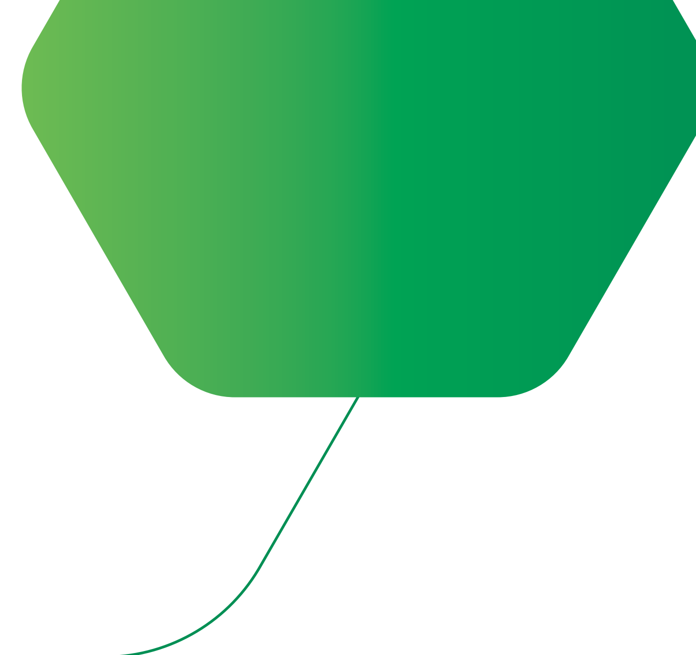
Stable and sustainable rate of growth

In addition to the work on safety and quality, IHPA published its eighth National Efficient Price Determination and seventh National Efficient Cost Determination for public hospital services. Supported by extensive consultation with jurisdictions and stakeholders, the Determinations have resulted in maintaining a stable and sustainable rate of growth in public hospital costs (see Figures 3 and 4).

Valuable stakeholder partnerships and collaboration

In delivering on these priorities, we engaged with and listened to our key stakeholders. IHPA continues to build on and foster its many strategic and trusted partnerships we share with all Australian governments, health peak bodies and associations.

I would also like to highlight the contributions made throughout the year by our Clinical Advisory Committee, whose advice is intrinsic to the decisions we make.



Managing risks

As part of its strategic direction, the Pricing Authority continues to offer oversight of the agency's strategic risk management, governance and compliance frameworks.

In 2018, the Authority worked with IHPA's senior executives to deepen its understanding of strategic risk management and developed a shared Strategic Risk Register with the National Health Funding Body to jointly manage risks related to the calculation of Commonwealth funding.

Commendation

This year the Pricing Authority said goodbye to Mr Jim Birch, Deputy Chair and one of the inaugural Authority members. I want to thank Jim for his valuable contributions over the last seven years, offering a wealth of expertise and knowledge to the Pricing Authority. I would also like to extend my thanks to all Pricing Authority members who provided expert vision and guidance throughout 2018–19.

On behalf of the Pricing Authority, I would like to commend James Downie, Chief Executive Officer for his transformational leadership. I also acknowledge the agency staff for their constant commitment to deliver a successful program of work in a timely manner.

Looking ahead

In an evolving environment, I am confident that we continue to build a solid foundation in how we undertake IHPA's purpose and functions. We remain committed to the highest standards of transparency and accountability, grounded in an open and consultative approach in working with Australian governments and other stakeholders.

In the year ahead, the Pricing Authority looks forward to contributing further to deliver sustainable, efficient and quality public hospital services for all Australians.

Shane Solomon

Chair, Pricing Authority
12 September 2019

Significant slowdown in costs

Cost per National Weighted Activity Unit (NWAU)

The NWAU is a measure of health service activity expressed as a common unit, against which the National Efficient Price is determined. Figure 3 indicates a significant reduction in the rate of growth in costs since 2011–12, to a sustained growth rate of 1.6%.

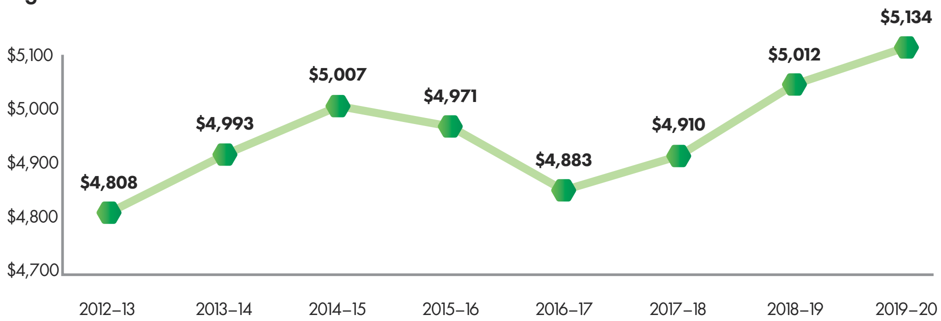
Figure 3: Cost per National Weighted Activity Unit (NWAU)

National Efficient Price

The National Efficient Price represents the average cost of a hospital admission across Australia, and is a determinant (along with the volume of services delivered) of the Australian Government's funding contribution to public hospitals. Figure 4, below, is an indicator of the success of activity based funding in controlling costs.

As required under the National Health Reform Agreement (cl A40), IHPA back-casts the National Efficient Price whenever significant changes to the methodology or underlying data occurs to enable the fair calculation of the Australian Government's growth funding.

Figure 4: National Efficient Price 2012–2019



About the Pricing Authority

The Pricing Authority is responsible for promoting improved efficiency in and access to public hospital services. They do this by providing independent advice to Australian governments in relation to the efficient costs of services, and developing and implementing robust systems to promote activity based funding for such services.

The Pricing Authority consists of a Chair, a Deputy Chair and seven other members.

Pricing Authority members are appointed for a period not greater than five years. The Chair is appointed by the Australian Government Minister for Health; the Deputy Chair is appointed with the agreement of First Ministers of all states and territories; and the remaining Pricing Authority members are appointed with the agreement of the Prime Minister and First Ministers of the states and territories.

Members of the Pricing Authority bring significant and varied expertise to their role including substantial experience and knowledge of the health industry, healthcare needs, and the provision of health care in regional and rural areas.

The Pricing Authority is supported by a Chief Executive Officer, who is responsible for the day-to-day running of IHPA.

All Pricing Authority members are non-executive.

Members of the Pricing Authority 2018–19

Members of the Pricing Authority bring significant and varied expertise to their role including substantial experience and knowledge of the health industry, healthcare needs, and the provision of health care in regional and rural areas.

About the Pricing Authority

Mr Shane Solomon (Chair)

Shane Solomon has over 30 years of international and national healthcare management expertise. Shane currently provides health strategy and advisory services, and holds non-executive director roles. Prior to this role, he was the founding Managing Director of Telstra Health, an e-health business within Telstra.

Previously, Shane was KPMG's Partner in Charge, Healthcare. In this role, he worked with state and Australian Governments, along with private sector health organisations.

Shane was the Chief Executive of the Hong Kong Hospital Authority, managing Hong Kong's 57,000 public hospital staff. During his five-year tenure, he implemented significant funding and service quality reforms, including a casemix pay-for-performance model, and the ongoing development of a comprehensive integrated e-health system.

In Victoria, Shane was Under-Secretary of Health at the Department of Human Services (as it then was), where he was responsible for managing the funding system (including casemix) for Victoria, and performance and governance of Melbourne metropolitan health services. He was responsible for developing the Hospital Admission Risk Program, and implementing governance reforms in Victoria's public hospital system.

Shane was the first Group Chief Executive Officer of the integrated Sisters of Mercy Victorian hospital and aged care services group, merging public hospitals, private hospitals, aged care services, and palliative care services into a single new organisation and expanding the Sisters of Mercy mission from five entities to twelve.

Mr Jim Birch (Deputy Chair)

Jim Birch is a board member of the Australian Red Cross Blood Service, the Australian Red Cross Society, Little Company of Mary Health Care, the Australian Digital Health Agency, Cancer Council of SA and Mary MacKillop Care SA.

Jim is a business consultant and was previously Global Health Leader of Ernst and Young, Lead Partner, Health and Human Services, and Government and Public Sector Lead Partner at Ernst and Young.

He has also held the position of Chief Executive of the Human Services and Health Department in South Australia.

Mr Glenn Appleyard

Glenn Appleyard was a member of the Australian Accounting Standards Board from 1 January 2003 to 31 December 2011.

Glenn has held several senior positions within the public service including Deputy Secretary in the Tasmanian and Victorian Departments of Treasury and Finance, and Regional Director for the Australian Bureau of Statistics in Tasmania.

He was a member of the Commonwealth Grants Commission for 11 years, and was also the Chair of the Tasmanian Economic Regulator. Glenn is currently the Chairman of PSMA Australia Ltd.

Associate Professor Bruce Chater

Associate Professor Bruce Chater is Head of the Academic Discipline of Rural and Remote Medicine at the University of Queensland. He performs these tasks from his rural base of Theodore, Queensland, where he continues as a practising rural doctor.

Bruce has been involved in ensuring that rural health services provide high quality and professional services to rural people. He was the founding convener of the Rural Doctors' Association of Queensland and Australia, founding Chair of the National Rural Health Alliance, Secretary of the Rural Working Party of the World Organisation of Family Doctors (WONCA) and served as President of the Australian College of Rural and Remote Medicine.

Ms Prudence Ford

Prudence Ford is a member of the Health Consumers' Council of WA. She was an inaugural member of the Medical Board of Australia, and was previously a member of the National Blood Authority, the National Health and Medical Research Council, the Brightwater Care Group Board and the Western Australian Medical Board.

Prudence has had 30 years' experience in the public service at Commonwealth and state levels. She has held senior executive positions in the then Commonwealth Departments of Community Services and Health, Finance, and the Attorney General, and in the Western Australian Departments of Health, and the Premier and Cabinet.

She was also an independent consultant for several years, undertaking a range of reviews, inquiries and projects for both the government and non-government sectors.

Prudence's experience encompasses policy development, program implementation, and delivery and corporate services.

Professor Jane Hall

Professor Jane Hall is Distinguished Professor of Health Economics in the Business School at the University of Technology, Sydney. She is a Fellow of the Academy of Social Sciences in Australia, and a Fellow of the Australian Academy of Health and Medical Sciences.

Jane has worked across many areas of health economics, including health technology assessment, measurement of quality of life, end of life care, health workforce, the economics of primary care, and funding and financing issues.

Jane established the Centre for Health Economics Research and Evaluation in 1990, and she remains in the Centre as Director, Strategy. She is engaged in health policy issues internationally through her involvement with the Commonwealth Fund International Program in Health Policy and Practice.

Jane has held many advisory and board positions and she is a former member of the board of the Bureau of Health Information. She is actively involved in policy analysis and critique, and is a regular commentator on health funding and organisational issues in Australia.

Dr Kate Taylor

Dr Kate Taylor is the Chief Executive Officer and Managing Director of Oculo, an internet-based platform for clinicians to share patient information. Kate is a member of the Australian Digital Health Agency's Clinical and Technical Advisory Committee. She was previously involved with the Board of the Mental Health Cooperative Research Centre in Australia, and internationally with the boards of Roll Back Malaria, Stop TB, and the GAVI Alliance.

Kate initially trained as an ophthalmologist, and also holds a Master of Public Health from Johns Hopkins University as a Fulbright Scholar. She has worked in strategy, policy and advocacy with McKinsey & Company, the World Economic Forum's Global Health Initiative, International AIDS Vaccine Initiative, and GlaxoSmithKline Biologicals. She brings experience in innovative partnerships, spanning new vaccine development through to innovative health financing, including the multi-billion dollar Advanced Market Commitment for pneumococcal vaccines and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr Michael Walsh

Dr Michael Walsh is Chief Executive of Cabrini Health, a private not-for-profit Catholic health service in Melbourne, Australia. He was recruited from Doha, Qatar, where he was Chief Executive of the National Health Authority. Prior to this, he worked in London, England as Chief Executive, South East London Strategic Health Authority.

Michael is a Fellow and current Vice President of the Royal Australasian College of Medical Administrators, and a Fellow of the Australasian College of Health Service Managers. Michael is a member of the Catholic Health Australia Stewardship Board, and he chairs the Health Policy Sub-Committee.

Michael has held a range of senior hospital and health department positions in Victoria and Western Australia. He has over 25 years' experience in health service policy and management, in both public and private sectors.

Ms Jennifer Williams

Jennifer Williams holds a number of board positions, including Chair of Northern Health, Yooralla and Alfred Whole Time Medical Specialist Trust.

She is also a member of the Australian Medical Research Advisory Board, and a Director of InfoXchange and Barwon Health. She has previously held the positions of Chief Executive of the Australian Red Cross Blood Service, Chief Executive of Alfred Health, and Chief Executive of Austin Health. She has also held senior management positions in the public and private sectors, including Director in the Victorian Department of Human Services.

Meetings of the Pricing Authority 2018–19

Table 1: Pricing Authority meetings and attendances 2018–19

Member	Meetings eligible	Meetings attended
Mr Shane Solomon (Chair)	11	11
Mr Jim Birch (Deputy Chair)	11	8
Mr Glenn Appleyard	11	11
A/Prof Bruce Chater	11	8
Ms Prudence Ford	11	8
Prof Jane Hall	11	10
Dr Kate Taylor	11	10
Dr Michael Walsh	11	7
Ms Jennifer Williams	11	10

The Pricing Authority met on 11 occasions between 1 July 2018 and 30 June 2019. The Chief Executive Officer, James Downie, as the accountable authority, attended all 11 meetings.

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IHPA 2018–19 overview

CEO's year in review

2018–19 proved to be another busy year for IHPA.

Reflecting on the agency's achievements over the past year, IHPA made significant progress with its work program. Its contribution to provide safe and high-quality health care can be seen through the many successful policy proposals presented throughout the year.

These policy priorities guided the strategic direction for our work as we continued to design the pricing systems to deliver high-quality, efficient and safe public hospital services for all Australians.

Key highlights

As well as setting the National Efficient Price and National Efficient Cost, we continued to develop and refine classification, counting and costing systems, which underpin the national activity based funding system.

A significant part of IHPA's work program for 2018–19 continued to be shaped by the safety and quality measures agreed by all Australian governments in 2016.

Last year, we presented the final stage of this work by developing new pricing approaches for avoidable hospital readmissions. These approaches are being trialled for a two-year shadow period from 1 July 2019.

2018–19 was a remarkable year in new classification development. IHPA finalised the first version of the new Australian Emergency Care Classification. We updated the admitted acute classification — Australian Refined Diagnosis Related Groups Version 10.0, which was the first time IHPA had undertaken this work in-house.

IHPA hosted another successful annual conference on activity based funding, which attracted around 440 healthcare professionals (see **Activity Based Funding Conference 2019 p47**).

Last but by no means least, we launched the WRITEitRIGHT® mobile application in January 2019. Developed as part of a suite of educational tools, this app aims to support the broad safety and quality reforms. It can help to reference the right diagnostic terms faster and more accurately. The app has been downloaded over 1,200 times, and IHPA continues to receive positive feedback from clinicians and health information managers alike.

Investing in partnerships

The achievements throughout 2018–19 would not be possible without the dedicated input and collaboration from our many stakeholders.

Responding to stakeholder needs and expectations continues to drive improvements in every area of our work. Following stakeholder feedback, in 2018 IHPA commenced a fundamental review of the National Pricing Model to inform future Determinations, which may better deliver on the objectives in the National Health Reform Agreement.

IHPA continues to place great value in work-life balance to help create a more productive, diverse and inclusive workplace.

Commendation

I take this opportunity to acknowledge the contributions of the Pricing Authority, particularly to our outgoing Deputy Chair Mr Jim Birch. Jim was an initial Authority member in 2012, and has had a significant influence on the course the Authority has taken over the past seven years. I also wish to thank the Clinical Advisory Committee for their expert guidance to deliver a clinically-relevant annual program of work.

I extend my thanks to the IHPA staff for their support and commitment once again. I am delighted to be leading an agency that strives for excellence in delivering its purpose.

IHPA continues to place great value in work-life balance to help create a more productive and inclusive workplace. We have built a diverse, gender-balanced senior-level leadership team. We also focus on creating a culture that fosters innovation, and one where leaders are committed to supporting and enabling our staff to achieve their best for themselves, the organisation and the Australian public.

Year ahead

In the year ahead, IHPA will continue its strategic direction as outlined in its Corporate Plan 2019–20 to ensure that we continue to deliver our core purpose.

James Downie

Chief Executive Officer, IHPA
12 September 2019

2018–19 highlights

Some of the key achievements from IHPA's Work Program for 2018–19 include:

March

- National Efficient Price and National Efficient Cost Determinations for 2019–20 published
- National Hospital Cost Data Collection, Public Hospital Cost Report, Round 21 (financial year 2016–17) published

April

- Three Year Data Plan 2019–20 to 2021–22 published
- Development work on Australian Refined Diagnosis Related Group Version 10.0 completed

May

- Activity Based Funding Conference 2019
- Consultation on IHPA's draft Work Program 2019–20
- National Hospital Cost Data Collection, Private Hospital Cost Report, Round 21 (financial year 2016–17) published
- Consultation on the non-admitted care costing study data collection

June

- Consultation on the Pricing Framework for Australian Public Hospital Services 2020–21
- IHPA's Work Program 2019–20 published
- The first version of the new Australian Emergency Care Classification finalised

July

- Australian Teaching and Training Classification Version 1.0 implemented

November

- Development work on the Australian Modification of the International Statistical Classification of Diseases Eleventh Edition completed

December

- Pricing Framework for Australian Public Hospital Services 2019–20 published

4

Clinical Advisory Committee

Annual Report

Letter from the Chair

It is a privilege to chair the Clinical Advisory Committee and to present the committee's Annual Report for 2018–19.

The Clinical Advisory Committee is a multidisciplinary group comprising members who bring extensive clinical knowledge, skills and expertise across many areas.

Drawing on this expertise and experience, the committee provides advice in relation to IHPA's program of work.

In 2018–19, the Clinical Advisory Committee continued to provide input into the Pricing Framework for Australian Public Hospital Services 2019–20, ensuring the policies outlined in it are clinically relevant and meet the needs of the clinical workforce. The committee provided advice and analysis to deliver clinically relevant National Efficient Price and National Efficient Cost Determinations for 2019–20.

The advisory committee played an essential role in providing clinical input to the options for pricing and funding for safety and quality reforms that were introduced as a result of the Addendum to the National Health Reform Agreement. This work included continued participation of the joint working party with the Australian Commission on Safety and Quality in Health Care, regarding the clinical aspect of IHPA's proposed funding options to reduce avoidable hospital readmissions.

The Clinical Advisory Committee also provided significant input into the development of national classification systems for emergency care, teaching and training, and mental health care. It provided substantial clinical advice on the Australian Refined Diagnosis Related Groups Version 10.0 and Australian Modification of the International Statistical Classification of Diseases Eleventh Edition.

I would like to thank my fellow committee members for their meaningful contribution and thoughtful consideration of the complex and at times highly technical issues. I express my deep appreciation for their commitment to improving efficiency, accountability and transparency across the public healthcare system.

This year the Clinical Advisory Committee said goodbye to Ms Sue Davis. I want to thank Sue for her valuable contributions over the years.

On behalf of the Clinical Advisory Committee, I acknowledge and commend the Pricing Authority, the IHPA Chief Executive Officer and staff for delivering a successful program of work in 2018–19.

I look forward to continuing to lead the work of the Clinical Advisory Committee for the coming year, and welcome the opportunity to support the agency to drive its strategic agenda in the year ahead.

Associate Professor
Alasdair MacDonald

Chair, Clinical Advisory Committee
12 September 2019

About the Clinical Advisory Committee

Clinical Advisory Committee members provide high-level technical and clinical advice to the Pricing Authority on a range of issues, such as activity based funding, classification development, IHPA policy development, and inform the National Efficient Price and National Efficient Cost.

The Clinical Advisory Committee is a statutory committee established under Part 4.10 of the *National Health Reform Act 2011.*

The functions of the committee are described in s. 177:

a. to advise the Pricing Authority in relation to developing and specifying classification systems for health care and other services provided by public hospitals

b. to advise the Pricing Authority in relation to matters that:

   i. relate to the functions of the Pricing Authority, and

   ii. are referred to the Clinical Advisory Committee by the Pricing Authority

c. to do anything incidental to or conducive to the performance of the above functions.

Membership

The members of the committee are appointed by the Australian Government Minister for Health, and are drawn from a range of clinical specialties and backgrounds to ensure the committee represents a wide range of clinical expertise.

Appointments are based on individual expertise rather than as a representative of an organisation, peak body or jurisdiction. Remuneration is determined by the Remuneration Tribunal.

The Chair of the committee, Associate Professor Alasdair MacDonald, reports to the Australian Government Minister for Health, and is supported by IHPA staff.

Table 2: Membership and meetings of the Clinical Advisory Committee in 2018–19

Name	Position	Specialty	Meetings eligible	Meetings attended
A/Prof Alasdair MacDonald	Chair	Internal Medicine	4	4
Prof Gerard Carroll	Member	Cardiology/Rural	4	2
Ms Sue Davis[1]	Member	Nursing	2	2
Ms Jan Erven	Member	Occupational Therapy	4	3
Mr Anthony Graham Fish	Member	Allied Health	4	4
Prof Leon Flicker	Member	Geriatrics/Indigenous Health	4	4
A/Prof Liza Heslop	Member	Nursing/Pregnancy and Childbirth	4	2
Dr Philip Hoyle	Member	Administration	4	2
A/Prof Louis Irving	Member	Respiratory/Indigenous Health	4	3
Dr Amod Karnik	Member	Intensive Care Medicine	4	3
Dr Amanda Ling	Member	Administration	4	2
Ms Amber Polles	Member	Pharmacy	4	4
Prof Sally Tracy	Member	Midwifery	4	3
A/Prof Melinda Truesdale	Member	Emergency Medicine	4	3
A/Prof Paul Varghese	Member	Geriatrics/Rehabilitation	4	4
Dr Ruth Vine	Member	Psychiatry	4	2
A/Prof Andrew Wei	Member	Haematology	4	1
A/Prof Bernard Whitfield	Member	Ear Nose and Throat Surgery/ Injuries/Trauma	4	3
A/Prof Daryl Williams	Member	Anaesthesia and Pain Management	4	1
W/Prof Fiona Wood	Member	Burns	4	0
Dr Jo Wright	Member	Rural Medical Practice	4	3
Dr Kathryn Zeitz	Member	Nursing	4	2

[1] Ms Sue Davis resigned from the Clinical Advisory Committee effective 30 November 2018.

Clinical Advisory Committee meetings 2018–19

20 August 2018

29 October 2018

4 February 2019

29 April 2019

2018–19 highlights

In 2018–19, the Clinical Advisory Committee supported IHPA's work program to deliver the following key achievements:

- The Pricing Framework for Australian Public Hospital Services 2019–20
- IHPA's determination of the National Efficient Price and National Efficient Cost for 2019–20
- Work to develop a new classification system for emergency care services
- Work to develop Version 10.0 of the Australian Refined Diagnosis Related Groups classification
- Work to develop new versions of the classifications for admitted acute care: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), the Australian Classification of Health Interventions (ACHI) and the Australian Coding Standards (ACS) Eleventh Edition, collectively known as ICD-10-AM/ACHI/ACS
- Work to refine the current version of the Australian National Subacute and Non-acute Patient classification
- Promotion of the WRITEitRIGHT® mobile application to champion accurate clinical documentation.

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Annual performance statements

Introductory Statement

I, James Downie, as the accountable authority of the Independent Hospital Pricing Authority (IHPA), present the 2018–19 annual performance statements of IHPA, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

In my opinion, these annual performance statements are based on properly maintained records, accurately reflect the performance of the entity, and comply with subsection 39(2) of the PGPA Act.

Performance in 2018–19

2018–19 Portfolio Budget Statements

Outcome 1

Promote improved efficiency in, and access to, public hospital services primarily through setting efficient national prices and levels of block funding for hospital activities.

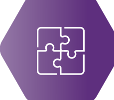
Program 1.1 Public Hospital Price Determinations

IHPA promotes improved efficiency in, and access to, public hospital services by providing independent advice to the Australian Government and state and territory governments regarding the efficient price of healthcare services, and by developing and implementing robust systems to support activity based funding for those services.

2018–19 Corporate Plan

Purpose

To determine the National Efficient Price and the National Efficient Cost for public hospital services

					
Strategic objective 1	**Strategic objective 2**	**Strategic objective 3**	**Strategic objective 4**	**Strategic objective 5**	**Strategic objective 6**
Perform IHPA pricing functions	Refine and develop hospital activity classification systems	Refine and improve hospital costing	Determine data requirements and collect data	Resolve disputes on cost-shifting and cross-border issues	Independent and transparent decision-making and engagement with stakeholders

2018–19 Annual Report: Performance statement

Results against performance criteria	**Results against performance criteria**	**Results against performance criteria**	**Results against performance criteria**	**Results against performance criteria**	**Results against performance criteria**
p40	p41	p43	p44	p45	p46

Figure 5: Relationship between 2018–19 Portfolio Budget Statements, IHPA Corporate Plan 2018–19 and the 2018–19 Annual Report Performance Statement

Summary of Performance for 2018-19

All performance measures required to meet the legislative requirements and obligations as outlined in the Work Program 2018–19 were achieved in 2018–19.

1. Perform IHPA pricing functions	
• Publish the Pricing Framework for Australian Public Hospital Services 2019–20 by 31 December 2018	Delivered
• Publish the National Efficient Price and National Efficient Cost Determinations by 31 March 2019	Delivered
• Undertake a fundamental review of the methodology underpinning the National Efficient Price	Ongoing
• Undertake a review of block funding services and the block funding model for small rural hospitals that underpins the National Efficient Cost	Delivered
• Undertake a global horizon scan to identify issues, solutions and innovations in health funding across the globe that could be incorporated into the Australian system to provide improvements	Ongoing
2. Refine and develop hospital activity classification systems	
• Seek input from clinicians and ensure acceptance of classification systems by committees including IHPA's Clinical Advisory Committee	Delivered
• Refine the Australian Teaching and Training Classification	Delivered
• Complete development work on a new classification system for emergency care services	Delivered
• Further refine the Australian Mental Health Care Classification	Delivered
• Continue development of the Subacute and Non-acute Patient Classification	Ongoing
• Develop a new classification for non admitted care services by undertaking a national non admitted costing study	Ongoing
• Complete development work on the Australian Refined Diagnosis Related Group Version 10.0 classification and Australian Modification of the International Statistical Classification of Diseases Eleventh Edition	Delivered
3. Refine and improve hospital costing	
• Establish and maintain national costing standards	Delivered
• Ensure effective collection and processing of costing information to support activity based funding outcomes	Delivered
• Review the format and content of the National Hospital Cost Data Collection Cost Report to identify relevant ways to present and narrate analysis	Delivered
• Work with jurisdictions to implement the Australian Hospital Patient Costing Standards Version 4.0	Delivered
4. Develop hospital data requirements and collect data	
• Publish the Three Year Data Plan 2019–20 – 2021–22	Delivered
• Publish a report on a quarterly rolling basis, outlining compliance with the data requirements and data standards specified in the rolling Three Year Data Plan	Delivered
• Add hospital acquired complication risk adjustments to the National Benchmarking Portal	Delivered
• Complete the annual review of Activity Based Funding National Best Endeavours Data Sets and National Minimum Data Sets	Delivered
• Further refine the secure data management system functionality to ensure IHPA remains at the forefront of data security and capability	Delivered

Results

Activity 1: Perform IHPA pricing functions

IHPA's primary function is to produce the National Efficient Price Determination and the National Efficient Cost Determination each year. The Pricing Framework for Australian Public Hospital Services forms the policy basis for the Determinations. The Pricing Framework outlines the principles, scope and methodology to be adopted by IHPA in the setting of the National Efficient Price and National Efficient Cost for public hospital services in the next financial year.

During 2018–19, IHPA undertook further technical development to improve the price-setting process and continue to refine the models used to determine the National Efficient Price and National Efficient Cost.

Performance criteria

1. Publish the Pricing Framework for Australian Public Hospital Services 2019–20 by 31 December 2018.
2. Publish the National Efficient Price and National Efficient Cost Determinations by 31 March 2019.
3. Reduce the number of local hospital networks that record costs per National Weighted Activity Unit significantly above the National Efficient Price.
4. Provide a further increase in the proportion of funding for public services using activity based funding as reported by the Administrator of the National Health Funding Pool.

Source

- 2018–19 Corporate Plan — Strategy 1
- 2018–19 Portfolio Budget Statement Program 1.1

Results against performance criteria

1. The Pricing Framework for Australian Public Hospital Services 2019–20 was published on 4 December 2018.
2. The National Efficient Price and National Efficient Cost Determinations were published on 5 March 2019.
3. The range between the 50th and 90th percentile decreased from $1,136 in 2015–16 to $1,070 in 2016–17, representing a reduction of $66.
4. During 2018-19, 83.25% of funding for public services paid by the Administrator of the National Health Funding Pool was based on activity based funding. This is a decrease of less than 1% from 2017–18.

Table 4: Proportion of funding for public hospital services using activity based funding

Year	Per cent
2013–14	82.43%
2014–15	83.08%
2015–16	85.42%
2016–17	83.95%
2017–18	83.35%
2018–19	83.25%

Activity 2: Refine and develop national classification systems

Activity based funding requires robust classification systems on which pricing can be based. Classifications aim to provide the healthcare sector with a nationally consistent method of classifying all types of patients, their treatment, and associated costs. IHPA has already determined the national classification systems for public hospital services, including admitted acute, non-admitted, emergency, subacute and mental health care.

Classifications are reviewed regularly and updated periodically to ensure that they remain clinically relevant and resource homogeneous within a service category. Such modifications are based on robust statistical analysis and include specialist input from clinicians.

During 2018–19, IHPA finalised the first version of the new Australian Emergency Care Classification and an updated version of the admitted acute classification, Australian Refined Diagnosis Related Groups Version 10.0. IHPA continued work to further develop the classifications for subacute care, non-admitted patient care and mental health care.

Performance criteria

1. Continue refinement of the Australian Mental Health Care Classification, specifically the refinement of the first level of the classification — the mental health phase of care.
2. Complete development of the classification for teaching and training.
3. Develop a new classification system for emergency care services.
4. Continue development of the subacute care classification using reported data and clinical advice.
5. Continue development work on the new classification for non-admitted care by preparing for a nationwide costing study.
6. Continue development work on the Eleventh Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, Australian Classification of Health Interventions, Australian Coding Standards; collectively known as ICD-10-AM/ACHI/ACS, for implementation from 1 July 2019.
7. Continue development work on the Australian Refined Diagnosis Related Groups Version 10.0 for release before 30 June 2019.

Source

- 2018–19 Corporate Plan — Strategy 2
- 2018–19 Portfolio Budget Statement Program 1.1

Results against performance criteria

1. In 2018–19, IHPA continued to refine the Australian Mental Health Care Classification, with specific focus on a project to clinically review and refine the phase of care to improve the classification and support data reporting.
2. IHPA released the Australian Teaching and Training Classification Version 1.0 in 2018–19. IHPA has also continued to build the reporting systems for the provision of teaching and training activity and cost data to support the implementation of the classification.
3. The development of the new Australian Emergency Care Classification was completed in 2018–19, based on analysis of the emergency care costing study data as well as feedback from public consultation. This classification places greater emphasis on patient factors such as diagnosis and complexity. It has greater capacity to incorporate additional factors that drive patient complexity and cost and has a superior performance when compared to the existing classification used for emergency department care.
4. Continue development of the subacute care classification using reported data and clinical advice.
5. Work on the development of the new Australian Non-Admitted Care Classification continued. During 2018–19 IHPA commenced project set-up and site selection for a national non-admitted costing study to collect non-admitted patient clinical, activity and cost data. The costing study design has been informed by a public consultation held in May 2019. This data set will be used to inform the development of the classification.
6. Development of the Eleventh Edition of ICD-10-AM/ACHI/ACS was completed during 2018–19, and is due for implementation from 1 July 2019.
7. Version 10.0 of the Australian Refined Diagnosis Related Groups classification was completed by IHPA during 2018–19, and will be used for pricing admitted acute episodes of care from 1 July 2020. Refinements were undertaken following clinical and statistical analysis and consultation with clinicians, jurisdictions and other stakeholders to ensure that the classifications remain current, clinically relevant, and adequately explain the costs of providing admitted acute hospital care.

Activity 3: Refine and improve hospital costing

Hospital costing focuses on the cost and mix of resources used to deliver patient care, and plays a vital role in activity based funding. Costing informs the development of classification systems and provides valuable information for pricing purposes.

A key output for IHPA is to coordinate the annual National Hospital Cost Data Collection, which is the primary input into the National Efficient Price. This includes the development of national costing standards, collection, validation, quality assurance, analysis and reporting, and benchmarking. The cost collection is undertaken in conjunction with states and territories, and private hospitals.

Performance criteria

1. Maintain national costing standards.
2. Ensure effective collection, processing and reporting of costing information to support activity based funding outcomes.
3. Review the format and content of the National Hospital Cost Data Collection Cost Report to identify relevant ways to present and narrate analysis of the cost report.

Source

- 2018–19 Corporate Plan — Strategy 3
- 2018–19 Portfolio Budget Statement Program 1.1

Result against performance criteria

1. Worked with jurisdictions to implement the Australian Hospital Patient Costing Standards Version 4.0.
2. The National Hospital Cost Data Collection (NHCDC) Round 22 (2017–18) data set was collected.
3. In 2018–19, IHPA reviewed and adapted the National Hospital Cost Data Collection (NCHDC) report into a set of accessible infographics designed to reach a wider audience.

Activity 4: Develop hospital data requirements and collect data

Timely, accurate and reliable public hospital data is vital to both the development of classifications for hospital services, and to determining the National Efficient Price of those services. IHPA has developed a rolling Three Year Data Plan to communicate to the Australian Government and states and territories the data requirements, data standards and timelines that IHPA will use to collect data over the coming three years. To ensure greater transparency, IHPA publishes data compliance reports on a quarterly basis that indicate jurisdictional compliance with the specifications in the rolling Three Year Data Plan.

Performance criteria

1. Update rolling Three Year Data Plan and publish on the IHPA website by June 2019.
2. Publish a report on a quarterly rolling basis, outlining compliance with the data requirements and data standards specified in the rolling Three Year Data Plan.
3. Develop appropriate data specifications, and ensure information provided for decision making meets those specifications.
4. Internal data assessment and compliance.
5. Receive assurance from jurisdictions regarding data quality/accuracy.

Source

- 2018–19 Corporate Plan — Strategy 4
- 2018–19 Portfolio Budget Statement Program 1.1

Result against performance criteria

1. The Three Year Data Plan was updated and published on the IHPA website in April 2019.
2. The quarterly data compliance reports were developed in consultation with jurisdictions and published on the IHPA website.
3. Activity based funding data submissions were assessed based on the published data standards, such as data set specifications and data request specifications.
4. The IHPA Data Compliance Policy was used to assess jurisdictional compliance ratings.
5. Jurisdictions were required to sign off their final data submission to IHPA, to ensure that data conforms as closely as is achievable in regard to its quality and accuracy. A Statement of Assurance, which provides detailed information about data quality and limitation, accompanies final data submission.

Activity 5: Resolve disputes on cost-shifting and cross-border issues

IHPA has a role to investigate and make recommendations concerning cross-border disputes between states and territories, and to make assessments of cost-shifting disputes.

Performance criteria

1. Review and publication of updated Cost-shifting and Cross-border Dispute Resolution Framework.
2. Investigation of cost-shifting or cross-border disputes and provision of recommendations or assessment within six months of receipt of the request.

Source

- 2018–19 Portfolio Budget Statement Program 1.1

Result against performance criteria

1. An updated Cost-shifting and Cross-border Dispute Resolution Framework (version 3.3) was approved for publication in June 2019.
2. In 2018–19 IHPA did not receive any requests relating to this function.

Activity 6: Independent and transparent decision-making and engagement with stakeholders

IHPA works in partnership with the Australian Government, state and territory governments and other stakeholders. IHPA conducts its work independently from governments, which allows the agency to deliver impartial, evidence-based decisions. It is transparent in its decision-making processes, and consults extensively across the health industry.

Extensive consultation with governments and stakeholders informs the methodology that underpins IHPA's decisions and work program. IHPA has a formal consultation framework in place, to ensure that it draws on an extensive range of expertise in undertaking its functions. Input from stakeholders, through IHPA's multiple committees and working groups, ensures that IHPA's work is informed by expert clinical advice, which helps to establish and consolidate IHPA's credibility throughout the industry.

Performance criteria

1. Appropriate committees and working groups maintained to support IHPA's functions.
2. Public consultation processes conducted in accordance with the *National Health Reform Act 2011*.
3. All stakeholder input is appropriately considered.
4. Inbox enquiries responded to within a two-week timeframe.
5. Annual national conference hosted for a broad audience in the health industry.

Source

- 2018–19 Corporate Plan
- 2018–19 Work Program

Results against performance criteria

1. In 2018–19 IHPA maintained up to 18 committees and working groups, to provide expert advice and to ensure the transparency and integrity of the organisation. During the reporting period, IHPA held 78 meetings with the various committees and working groups.
2. IHPA conducted five public consultation processes in 2018–19, each in accordance with the *National Health Reform Act 2011*. These included:
   i. Pricing Framework for Australian Public Hospital Services 2019–20 (July 2018)
   ii. Refinement of the Eleventh Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, the Australian Classification of Health Interventions and the Australian Coding Standards (ICD-10-AM/ACHI/ACS) (August 2018)
   iii. IHPA Work Program 2019–20 (May 2019)
   iv. Development of the Australian Non-Admitted care costing study for data collection (May 2019).
3. All submissions received by IHPA, as part of consultation processes, were presented to the Pricing Authority for consideration and published on the IHPA website.
4. IHPA received 60 inbox enquiries during the reporting period. IHPA responded to 87% within two weeks and to 40% of those on the day of receipt.

Table 5: Response rate to enquiries 1 July 2018 – 30 June 2019

Total request	Same day response	1–7 days	7–14 days	15+ days
60	24	26	2	8

5. IHPA hosted its Activity Based Funding Conference 2019 in Melbourne from 13–15 May. The conference attracted around 440 healthcare professionals from across Australia and around the world. It had a three-day program of workshops, keynote, plenary and panel sessions (see **Activity Based Funding Conference p47**).

Activity Based Funding Conference 2019

Headline statistics

- **438** delegates attended
- **More than half** of the attendees were first timers
- **90%** had a positive overall impression
- **66** speakers presented
- **200** mentions on social media with a potential reach of **333,000** impressions across the three-day conference

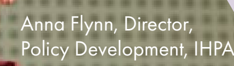
Professor Christine Bennett AO, Dean, School of Medicine, The University of Notre Dame Australia

Women in STEM Leadership panel discussion

IHPA held its seventh Activity Based Funding (ABF) Conference in Melbourne from 13–15 May 2019 under the theme *'Activity Based Funding: Cost, value and outcomes'.*

IHPA's annual conference aimed at providing high-quality education in activity based funding and the underlying classification, costing and data collection systems to key health sector personnel.

The Activity Based Funding Conference 2019 attracted around 440 healthcare professionals from across Australia and around the world. It included keynote sessions, major plenary sessions, concurrent smaller presentations, workshops, and networking activities.


Anna Flynn, Director, Policy Development, IHPA

Professor Andrew Street, Professor of Health Economics, Department of Health Policy, The London School of Economics and Political Science

Joanne Fitzgerald, Executive Director, Policy and Classification, IHPA

Welcome to Country performed by Wurundjeri Elder Uncle Ian Hunter

Anne Elsworthy, Director, Acute Care Classifications, IHPA

Dr Jason Sutherland, Associate Professor, Centre for Health Services and Policy Research, University of British Columbia

James Downie, Chief Executive Officer, IHPA and Shane Solomon, Chair, Pricing Authority

Analysis

IHPA has had another productive year, meeting its performance criteria and deliverables in IHPA's corporate plan and work program for 2018–19.

The IHPA Work Program 2018–19 provides a more detailed set of goals and deliverables than those included in the Portfolio Budget Statements and IHPA's Corporate Plan. It is developed each year through a consultative process with government and health sector stakeholders, and is published on the IHPA website (see **www.ihpa.gov.au/publications**).

Work priorities identified through our stakeholder committees and working groups have been achieved, or significant progress has been demonstrated. A major focus last year has been the work towards pricing and funding for safety and quality. The approach to the implementation of pricing and funding for safety and quality has been rolled out on a staged basis.

Funding adjustments related to sentinel events were introduced in July 2017, followed by funding adjustments for hospital acquired complications in July 2018.

IHPA progressed the final stage of this work to reduce avoidable hospital readmissions, which arise from complications in the management of the patient's original hospital admission.

The Australian Health Minister's Advisory Council approved a list of avoidable hospital readmissions developed by the Australian Commission on Safety and Quality in Health Care. IHPA is currently shadowing funding options to analyse their impact in preventing avoidable hospital readmissions over a 24-month period commencing 1 July 2019.

IHPA has been able to meet these challenges in a professional and timely manner, while continuing to achieve the criteria set out in its annual work program.

The Australian Refined Diagnosis Related Groups classification continues to be well regarded within Australia and internationally, and is currently licensed for use in 17 countries around the world.

For the first time, IHPA included data on hospital acquired complications via its National Benchmarking Portal, enabling hospital managers to better understand the impact of hospital acquired complications across Australian public hospital services.

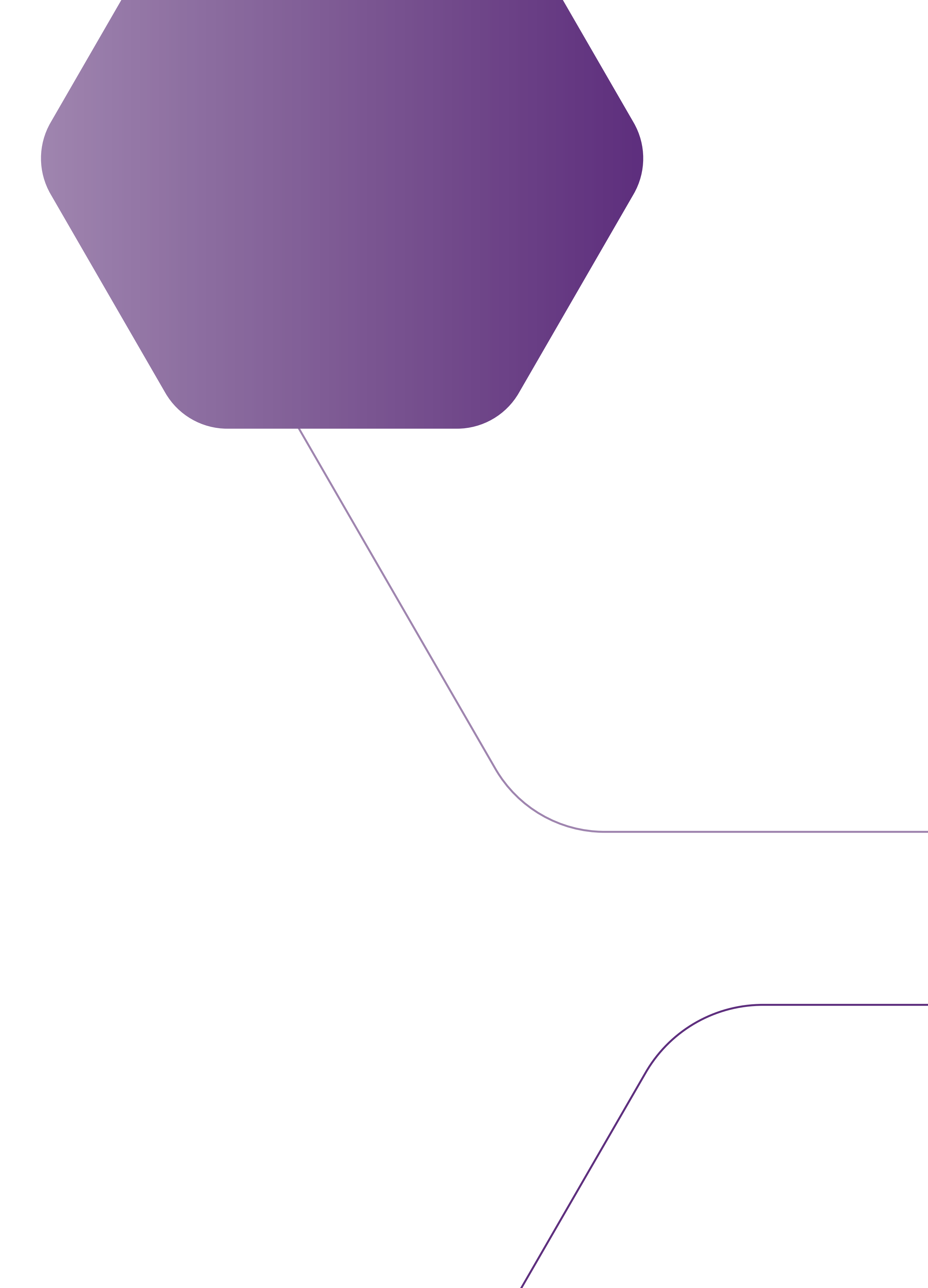
The portal is a secure, web-based application. It provides an important way to recognise the critical role that data plays in IHPA's work, and is a key driver in safety and quality measures going forward.

IHPA has a challenging role in communicating intricate, highly technical and complex information related to the public hospital costs and funding in Australia. In 2018–19, we demonstrated that we were up to the challenge. For the first time, we adapted the National Hospital Cost Data Collection (NCHDC) report into a set of succinct and accessible infographics designed to reach a wider audience. These infographics have succeeded in generating strong interest in the NHCDC.

The National Efficient Price and National Efficient Cost Determinations for 2018–19 continue to demonstrate the benefits of activity based funding in reducing costs (see **p17**).

With the increasing demand for health services, there is an opportunity to encourage more preventive interventions as well as integrated services that can reduce the need for hospital admissions. IHPA undertook a global horizon scan in 2018 to learn best practices that can be adapted to incorporate value-based funding models to focus on hospital avoidance and improve patient outcomes. This included a visit to selected institutions in the United States including Centers for Medicare and Medicaid Services, Maryland; 3M Health Care, Washington DC; New York State Department of Health; and Staten Island University Hospital.

In addition, IHPA will continue to drive internal process improvements, with a focus on refining funding models, learning and development, and data use and analysis. Along with exploring opportunities for the new long-term, system-wide reforms focusing on value and outcome-based health, IHPA will continue to work in collaboration with a broad range of stakeholders to improve health outcomes for Australians and increase the effectiveness of Australia's current hospital funding system.



6

Management and accountability

Key corporate governance practices

Since the agency's formation in 2011, IHPA's accountable authority has established a robust system of risk management and controls to assist in the governance of the agency.

The Pricing Authority delivers the functions defined in the *National Health Reform Act 2011*. The Pricing Authority approves IHPA's core business activities — determination of the National Efficient Price and the National Efficient Cost for public hospital services annually, and building national classification systems for all hospital services. The Chief Executive Officer is responsible for IHPA's day-to-day administration.

Risk management

IHPA's enterprise approach to risk management remains the administration of risk using tools that address the strategic and tactical risks of all significant decisions. IHPA updated its risk management framework and developed a detailed risk appetite statement in 2018.

Strategic risks are identified with reference to current business and environmental issues facing IHPA. These risks fall into three major risk categories:

- reputational risks
- data and information governance risks
- corporate risks.

Additionally, IHPA developed a shared Strategic Risk Register with the National Health Funding Body, which identified two risks that both agencies have agreed to manage jointly:

- incorrect calculation of Commonwealth funding entitlements
- changes to models that have not been effectively modelled and/or implemented.

IHPA's strategic risks are actively managed through audits, assurance, and control processes. Where new risks emerge, resources are assigned to understand and manage those risks.

Tactical risks are managed through a decision-based risk management tool. This is a particularly useful process in regard to procurement, and information and communication technology risks, as it requires recording of the risk and a formal decision on the managed likelihood and consequence of the risk. The assessment tool forms part of any major decision, ensuring that the final decision maker is fully informed and cognisant of managed risk outcomes during the decision-making process.

IHPA has a mature enterprise risk management framework in place, and risk management is considered a business-as-usual activity for all IHPA staff.

Compliance

IHPA has a broad range of compliance obligations, including key statutory obligations set out in the *National Health Reform Act 2011* and the National Health Reform Agreement, the *Public Governance Performance and Accountability Act 2013*, and the Public Governance Performance and Accountability Rule 2014.

Other legal and compliance obligations include, work health and safety, privacy, freedom of information, intellectual property, the Protective Security Policy Framework, website accessibility and records management.

The Chief Executive Officer as the accountable authority receives management assurances on IHPA's compliance obligations through an organised system of controls and special exercises, including substantive testing, monthly reports, exception notifications, and compliance audits undertaken by an independent internal auditor.

Compliance achievements during the year include:

- IHPA was subject to review by the Australian National Audit Office as part of its performance audit on the "*Australian Government Funding of Public Hospital Services — Risk Management and Data Monitoring and Reporting arrangements*" along with the Department of Health and the National Health Funding Body. The audit made no negative findings or recommendations against IHPA.
- IHPA commissioned PricewaterhouseCoopers to review the implementation of its secure data management system. In October 2018, IHPA received a report that concluded the system was delivered on time and within budget, and met IHPA's operational requirements. It also concluded that the secure data management system had been designed to meet all Commonwealth data security requirements, as well as IHPA's local security and access requirements.
- IHPA's internal compliance audits continue to show that information and communications technology systems were assessed as appropriately addressing the top risks defined by the Australian Signals Directorate.
- A review by independent auditors concluded IHPA's management of its classification licensing product sales was effective, and that the environment in which they were managed was satisfactory.
- No compliance issues arising from IHPA's administration of relevant sections of the *National Health Reform Act 2011*.
- No material compliance issues emanating from the *Public Governance Performance and Accountability Act 2013*.

Financial authorisation

As a corporate Commonwealth Agency, IHPA is not required to adhere to the Commonwealth Procurement Rules, but chooses to do so as a matter of best practice. All IHPA's procurement decisions are made in accordance with the Commonwealth Procurement rules. Line managers have value and purchase class limits in accordance with the delegation of financial authorities that is approved and reviewed regularly by the Chief Executive Officer, as the accountable authority.

Audit, Risk and Compliance Committee

The IHPA Audit, Risk and Compliance Committee provides independent advice to the Chief Executive Officer on managing IHPA's financial and business risk.

At 30 June 2019, members of the Audit, Risk and Compliance Committee comprised:

- Robert Butterworth, Chair and Independent member
- Angela Diamond, Independent member
- Alan Bansemer, Independent member
- Glenn Appleyard, Member of the Pricing Authority[1].

Fraud control plan

IHPA's fraud control plan is recognised as a critical internal tool used to mitigate the act and consequences of unauthorised use of IHPA data and financial resources. It was updated in October 2018 to incorporate changes to the Commonwealth Fraud Control Framework. The plan encourages ethical behaviour through use of business processes designed to prevent deceptive activities, supported by monitoring controls to detect fraud and deter offending behaviour.

[1] Mr Appleyard was appointed to the Audit, Risk and Compliance Committee with effect from 1 January 2019.

Inter-agency financial activity

During the 2018–19 financial year, IHPA received shared services resourcing from the Department of Health.

The Department of Health charged IHPA $277,000 to provide these services covering treasury, processing of financial transactions, information and communication desktop services, and parliamentary support.

Ecologically sustainable development and environmental performance

IHPA does not undertake any substantive work that is covered by s. 516A of the *Environment Protection Act 1999*.

Management of human resources

The Chief Executive Officer is IHPA's only employee and is based in Sydney NSW. All other staff are seconded from the Department of Health. The Department of Health will report on IHPA staff as part of its staffing numbers; however, to ensure transparency, IHPA will report separately on those staff who have been seconded to IHPA and report to the Chief Executive Officer.

IHPA continues to place great value in creating a more productive and inclusive workplace—primarily by attracting and retaining high-calibre, talented and engaged staff. The agency supports a flexible work environment, and will continue to support all staff to optimise balance between their work and outside factors, as well as providing technological support critical to achieving their required work performance.

Workplace diversity

IHPA is committed to the recruitment and retention of a diverse (e.g. in gender, age, cultural and linguistic background, disability, Indigenous, and LGBTI+) workforce, and actively promotes an inclusive workplace culture.

The 2019 Australian Public Service Commission Employee Census indicated that IHPA is a highly diverse workplace with an inclusive, collegial and engaged culture.

- 59% female
- 53% of senior management positions are held by women
- 45% of the workforce identifies as being born outside Australia
- 38% of the workforce speaks a language other than English at home
- 7% of the workforce identifies as Aboriginal and Torres Strait Islander peoples.

At the 2019 Employee Census, 93% of respondents indicated the agency is committed to creating a diverse workforce, while 100% said the staff in the agency behave in an accepting manner towards people from diverse backgrounds.

Employee engagement

The 2019 Census results indicate IHPA has a 76% employee engagement score.

- 97% of participants stated they believe strongly in the purpose and objectives of the agency, and feel committed to the agency's goals.
- 93% said they are happy to go the 'extra mile' at work when required.
- 76% said they are proud to work for IHPA, and felt a strong attachment to the agency.
- 85% said they have a clear understanding of how their workgroup's role contributes to the agency's strategic direction.
- 83% indicated they are satisfied with their job
- 93% said they suggest ideas to improve ways of doing things.

Ongoing Employees

The Chief Executive Officer is IHPA's only employee and is based in Sydney NSW (no change from prior year).

All other staff are seconded from the Department of Health and report through to the Chief Executive Officer. Although the Department of Health reports on seconded IHPA staff as part of its mandatory reporting requirements, to ensure transparency IHPA has provided the following staffing tables.

Table 6: Ongoing seconded employees

2019

	Male			Female			
Classification	**Full-time**	**Part-time**	**Total**	**Full-time**	**Part-time**	**Total**	**Total**
SES	0	0	0	2	0	2	2
EL2	5	0	5	5	0	0	10
EL1	8	0	8	8	4	12	20
APS Level 6	5	0	5	6	2	8	13
APS Level 5	0	0	0	1	0	1	1
Total	**18**	**0**	**18**	**22**	**6**	**28**	**46**

2018

	Male			Female			
Classification	**Full-time**	**Part-time**	**Total**	**Full-time**	**Part-time**	**Total**	**Total**
SES	0	0	0	2	0	2	2
EL2	5	0	5	4	0	0	9
EL1	8	0	8	3	5	8	16
APS Level 6	3	0	3	4	2	6	9
APS Level 5	0	0	0	2	0	2	2
Total	**16**	**0**	**16**	**14**	**8**	**22**	**38**

Table 7: Non-ongoing seconded employees

2019

	Male			Female			
Classification	**Full-time**	**Part-time**	**Total**	**Full-time**	**Part-time**	**Total**	**Total**
SES	0	0	0	0	0	0	0
EL2	0	0	0	0	1	1	1
EL1	1	0	1	0	1	1	2
APS Level 6	1	0	1	1	0	1	2
APS Level 5	0	0	0	0	0	0	0
Total	**2**	**0**	**2**	**1**	**2**	**3**	**5**

2018

	Male			Female			
Classification	**Full-time**	**Part-time**	**Total**	**Full-time**	**Part-time**	**Total**	**Total**
SES	0	0	0	0	0	0	0
EL2	1	0	1	0	0	0	1
EL1	0	0	0	0	1	1	1
APS Level 6	0	0	0	1	0	1	1
APS Level 5	0	0	0	0	0	0	0
Total	**1**	**0**	**1**	**1**	**1**	**2**	**3**

Key management personnel

Table 8: Information about remuneration for key management personnel (KMP)

		Short term benefits			Post-employment benefits	Other long term benefits			
Name	**Position title**	**Base salary $**	**Bonuses $**	**Other benefits and allowances $**	**Superannuation Contributions $**	**Long service leave $**	**Other long term benefits $**	**Termination benefits $**	**Total renumeration $**
Glenn Appleyard	Pricing Authority member	33,115[1]	–	–	5,100	–	–	–	38,215
Jim Birch	Pricing Authority member (Deputy Chair)	31,115	–	–	2,956	–	–	–	34.071
Bruce Chater	Pricing Authority member	31,115	–	–	2,956	–	–	–	34,071
James Downie	Chief Executive Officer	433,599	–	–	20,151	7,535	–	–	461,285
Prudence Ford	Pricing Authority member	31,115	–	–	2,956	–	–	–	34,071
Jane Hall	Pricing Authority member	31,115	–	–	2,956	–	–	–	34,071
Shane Solomon	Pricing Authority member (Chair)	83,947	–	–	7,975	–	–	–	91,922
Kate Taylor	Pricing Authority member	31,115	–	–	2,956	–	–	–	34,071
Michael Walsh	Pricing Authority member	31,115	–	–	2,956	–	–	–	34,071
Jennifer Williams	Pricing Authority member	31,115	–	–	2,956	–	–	–	34,071
Total		**768,466**	**–**	**–**	**53,918**	**7,535**	**–**	**–**	**829,919**

The above disaggregated KMP remuneration information is in accordance with the Public Governance, Performance and Accountability Rule 2014. Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any Pricing Authority member. The entity has determined the key management personnel to be the Chief Executive Officer and the Pricing Authority members. The remuneration in the table above is based on the relevant remuneration tribunal determinations for holders of full-time and part-time public office.

[1] Base salary includes Audit Review and Compliance Committee sitting fees

Staff development

IHPA cultivates, values and supports staff by developing their skills and capabilities to meet their work requirements, as well as to achieve their full potential. We promote a culture where people work within and across teams to broaden their expertise.

Training was provided on a programmed basis to management and a needs basis to individual staff. Additionally, mid-level and senior management staff undertook a program of leadership training.

IHPA supported individuals to attend conferences and training events that assisted them to acquire and develop skills used in their work. In 2018–19, IHPA's training investment averaged $3,945 per staff member.

The accountable authority

Under the *National Health Reform Act 2011*, the Chief Executive Officer is the accountable authority.

The Chief Executive Officer is responsible for the effective delivery of IHPA's work program and supports the Pricing Authority to fulfil its functions.

Mr James Downie was appointed as the IHPA CEO on 1 September 2016. Prior to this James was Executive Director, Activity Based Funding, leading the teams responsible for delivering the classification, costing and pricing functions of IHPA as well as the data acquisition activities.

He previously held roles with the Victorian Department of Health and the Royal Children's Hospital Melbourne, and various technical and operational roles in the resources industry.

He holds a Masters of Business Administration and Bachelor of Engineering in Metallurgical Engineering.

Education and review processes

During the reporting period, the Chief Executive Officer enhanced his skills through attendance at domestic and international activity based funding events, and attended specialised leadership training that was also made available to IHPA mid-level and senior management staff.

The Chief Executive Officer receives regular performance feedback via the Pricing Authority meetings.

Work health and safety

In 2018–19, IHPA's Work Health and Safety Committee continued to manage work health and safety matters in accordance with the *Work Health and Safety Act 2011*.

The committee met four times during the year and dealt with a range of work health and safety matters.

IHPA maintained its ongoing practice of providing workplace assessments for new staff, and as required.

In 2018–19 no notifiable incidents were identified in regards to work health and safety. No workers reported injuries and no workers compensation claims were lodged. There were no investigations conducted during the year relating to businesses or undertakings conducted by the entity.

Advertising and market research

In 2018–19, IHPA commissioned no advertising that must be reported under s. 311A of the *Commonwealth Electoral Act 1918*.

7

Financial management

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Statement by the Chief Executive Officer and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2019 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Independent Hospital Pricing Authority will be able to pay its debts as and when they fall due.

James Downie

Chief Executive Officer
6 September 2019

Chris Miljak

Chief Financial Officer
6 September 2019

Australian National Audit Office report

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Independent Hospital Pricing Authority ('the Entity') for the year ended 30 June 2019:

(a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Entity as at 30 June 2019 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following statements as at 30 June 2019 and for the year then ended:

- Statement by the Chief Executive Officer and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement; and
- Notes to the financial statements, comprising a Summary of Significant Accounting Policies and other explanatory information.

Basis for opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of my report. I am independent of the Entity in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's responsibility for the financial statements

As the Accountable Authority of the Entity, the Chief Executive Officer is responsible under the *Public Governance, Performance and Accountability Act 2013* (the Act) for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under the Act. The Chief Executive Officer is also responsible for such internal control as the Chief Executive Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Chief Executive Officer is responsible for assessing the ability of the Entity to continue as a going concern, taking into account whether the Entity's operations will cease as a result of an administrative restructure or for any other reason. The Chief Executive Officer is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

GPO Box 707 CANBERRA ACT 2601
19 National Circuit BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

Auditor's responsibilities for the audit of the financial statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Accountable Authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Australian National Audit Office

Sean Benfield
Executive Director
Delegate of the Auditor-General

Canberra
9 September 2019

Primary financial statements

Statement of comprehensive income

for the preriod ended 30 June 2019

	Notes	2019 $'000	2018 $'000	Original Budget $'000
NET COST OF SERVICES				
EXPENSES				
Employee benefits	1.1A	**6,763**	6,250	7,126
Suppliers	1.1B	**17,034**	11,353	15,522
Depreciation and amortisation	2.2A	**365**	348	475
Total expenses		**24,162**	17,951	23,123
OWN-SOURCE INCOME				
Own-source revenue				
Sale of goods and rendering of services	1.2A	**2,079**	1,268	1,120
Interest		**177**	208	120
Resources received free of charge	1.2B	**6,423**	5,861	7,086
Total own-source revenue		**8,679**	7,337	8,326
Gains				
Other gains	1.2C	**27**	186	-
Total gains		**27**	186	-
Total own-source income		**8,706**	7,253	8,326
Net cost of services		**15,456**	10,428	14,797
Revenue from Government	1.2D	**15,487**	14,476	14,797
Surplus		**31**	4,048	-
Total comprehensive surplus		**31**	4,048	-

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Statement of Comprehensive Income

Total expenses of $24.162m were higher than the budgeted amount of $23.123m. The main driver of the overspend was supplier expenses, which were higher than budget due to increased program activity with projects running ahead of schedule and increased spending on secure data management systems. Total own source income of $8.706m was higher than the budgeted amount of $8.326m, primarily due to higher sales of goods and services. Resources received free of charge were lower than budget due to lower than expected staff levels.

Statement of financial position

as of 30 June 2019

	Notes	2019 $'000	2018 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	2.1A	**13,896**	13,712	9,698
Trade and other receivables	2.1B	**1,132**	80	707
Total financial assets		**15,028**	13,792	10,405
Non-financial assets				
Leasehold improvement	2.2A	**234**	292	305
Plant and equipment	2.2A	**201**	276	320
Computer software	2.2A	**368**	555	502
Other intangibles	2.2A	**38**	77	41
Other — prepayments		**155**	153	254
Total non-financial assets		**996**	1,353	1,422
Total assets		**16,024**	15,145	11,827
LIABILITIES				
Payables				
Suppliers	2.3A	**3,099**	2,174	2,700
Other payables	2.3B	**72**	7	109
Total payables		**3,171**	2,181	2,809
Provisions				
Employee provisions	3.1A	**85**	76	143
Other provisions	2.4	**-**	151	186
Total provisions		**85**	227	329
Total liabilities		**3,256**	2,408	3,138
Net assets		**12,768**	12,737	8,689
EQUITY				
Contributed equity		**400**	400	400
Asset revaluation reserve		**74**	88	88
Retained surplus		**12,294**	12,249	8,201
Total equity		**12,768**	12,737	8,689

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Statement of Financial Position

Total assets of $16.024m were higher than the budget of $11.827m, principally due to higher cash balance as a result of the prior year surplus.

Total liabilities of $3.256m were marginally higher than the budget of $3.138m as higher payables were partially offset by lower provisions.

Total equity of $12.768m was higher than the budget of $8.689m due to the prior period surplus noting that the budget is derived on a break-even assumption.

Statement of changes in equity

for the period ended 30 June 2019

	Notes	2019 $'000	2018 $'000	Original Budget $'000
CONTRIBUTED EQUITY				
Opening balance				
Balance carried forward from previous period		**400**	400	400
Closing balance as at 30 June		**400**	400	400
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		**88**	88	88
Transfer to retained earnings				
From disposal of revalued assets		**(14)**	-	
Closing balance as at 30 June		**74**	88	88
RETAINED EARNINGS				
Opening balance				
Balance carried forward from previous period		**12,249**	8,201	8,201
Transfer from asset revaluation reserve				
From disposal of revalued assets		**14**	-	-
Comprehensive income				
Surplus for the period		**31**	4,048	-
Closing balance as at 30 June		**12,294**	12,249	8,201
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		**12,737**	8,689	8,689
Comprehensive income				
Surplus for the period		**31**	4,048	-
Closing balance as at 30 June		**12,768**	**12,737**	8,689

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Statement of Changes in Equity

Total equity of $12.768m was higher than the budget of $8.689m due to the prior period surplus noting the budget is derived on a break-even assumption.

Cash flow statement

for the period ended 30 June 2019

	Notes	2019 $'000	2018 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Receipts from Government		**14,797**	14,476	14,797
Sale of goods and rendering of services		**1,994**	1,459	1,198
Interest		**179**	208	120
Net GST received		**1,237**	1,044	1,380
Total cash received		**18,207**	17,187	17,495
Cash used				
Employees		**(768)**	(774)	(850)
Suppliers		**(17,223)**	(12,489)	(16,037)
Total cash used		**(17,991)**	(13,263)	(16,887)
Net cash from operating activities		**216**	3,924	608
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment		**-**	(5)	(600)
Purchase of computer software		**(10)**	-	-
Purchase of leasehold improvement		**(22)**	-	-
Total cash used		**(32)**	(5)	(600)
Net cash used by investing activities		**(32)**	(5)	(600)
Net increase in cash held		**184**	3,919	8
Cash and cash equivalents at the beginning of the reporting period		**13,712**	9,793	9,690
Cash and cash equivalents at the end of the reporting period	2.1A	**13,896**	13,712	9,698

The above statement should be read in conjunction with the accompanying notes.

Budget Variances Commentary

Statement of Changes in Cash Flow

The closing cash balance of $13.896m was higher than the budgeted amount of $9.698m primarily due to the prior period surplus, noting the budget is derived on a break-even assumption.

Overview

Objectives of the Independent Hospital Pricing Authority

The Independent Hospital Pricing Authority (IHPA) is a corporate Commonwealth entity under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

IHPA's role and functions are set out in the *National Health Reform Act 2011*.

IHPA's functions include, to:

- Determine the National Efficient Price and National Efficient Cost for public hospital services;
- Develop national classifications for Activity Based Funding; and
- Resolve disputes on cost-shifting and cross-border issues.

IHPA is structured to meet the following outcome: promote improved efficiency in, and access to, public hospital services primarily through setting the national efficient price and levels of block funding fo hospital activities.

The continued existence of the entity in its present form, and with its present programs, is dependent on Government policy and on continuing funding by Parliament for the entity's administration and programs.

The basis of preparation

The financial statements are general purpose financial statements and are required by section 42 of the PGPA Act.

The financial statements have been prepared in accordance with the:

a) Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR) for reporting periods ending on or after 1 July 2018; and

b) Australian Accounting Standards and Interpretations — Reduced Disclosure Requirements issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position. The financial statements are presented in Australian dollars and values are rounded to the nearest thousand dollars, unless otherwise specified.

Significant changes affecting IHPA during 2018–19

No significant changes affecting IHPA have occurred in this reporting period.

New Australian Accounting Standards

Adoption of new Australian Accounting Standard requirements

IHPA has adopted all new, revised and amending standards and interpretations that were issued by the Australian Accounting Standards Board (AASB) prior to the sign-off date and which are applicable to the current reporting period. The adoption of these standards and interpretations did not have a material effect, and are not expected to have a future material effect, on the financial statements.

Future Accounting Standard requirements

The following new, revised and amending standards and interpretations were issued by the AASB prior to the signing of the statement by the Chief Executive Officer and Chief Financial Officer:

New standard	Expected impact
AASB 15 *Revenue from Contracts with Customers*	No impact anticipated
AASB 1058 *Income of Not-for-Profit Entities*	No impact anticipated
AASB 16 *Leases*	An overall increase in expenses related to lease agreements in reporting periods following adaption with expenses decreasing over the term. Leases are limited to the office accommodation lease.

All other new, revised and amending standards or interpretations that have been issued by the AASB prior to sign-off date that are applicable to future reporting period(s) are not expected to have a future material financial impact on IHPA's financial statements.

Significant accounting judgements and estimates

Except where specifically identified and disclosed, IHPA has determined that no accounting assumptions and estimates have a significant risk of causing a material adjustment to carrying amounts of assets and liabilities within the next accounting period.

Comparative figures

Comparative figures have been adjusted, where required, to conform to changes in presentation of the financial statements.

Taxation

IHPA is exempt from all forms of taxation, except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses, assets and liabilities are recognised net of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office.

Events after the reporting period

No events have occurred since the reporting date which have had a material impact on the financial statements.

Notes to financial statements

Financial performance

This section analyses the financial performance of IHPA for the year ended 30 June 2019.

Note 1.1 Expenses

	2019 $'000	2018 $'000
Note 1.1A: Employee Benefits		
Wages and salaries	**545**	508
Superannuation		
Defined contribution plans	**60**	67
Leave and other entitlements	**267**	254
Wages and salaries for staff provided by Department of Health	**5,891**	5,421
Total employee benefits	**6,763**	6,250

Accounting Policy

Employee benefits

Accounting policies for employee benefits is contained in the People and relationships section.

	2019 $'000	2018 $'000
Note 1.1B: Suppliers		
Goods and services supplied or rendered		
Consultants	**7,330**	4,312
Contractors	**3,833**	2,550
IT services	**2,849**	1,927
Travel	**371**	294
Training	**170**	141
Publishing materials	**512**	267
Legal expenses and audit fees	**200**	226
Conferences and seminars	**633**	763
Other	**381**	343
Total goods and services supplied or rendered	**16,279**	10,823
Goods supplied	**658**	337
Services rendered	**15,621**	10,486
Total goods and services supplied or rendered	**16,279**	10,823
Other suppliers		
Operating lease rentals in connection with minimum lease payments	**751**	528
Workers compensation expenses	**4**	2
Total other suppliers	**755**	530
Total suppliers	**17,034**	11,353

Leasing commitments

On 1 June 2018, IHPA in its capacity as lessee entered into a 5 year lease (with 5 year extension option) for office accommodation. The lease is subject to an annual cost increase and is not able to be cancelled.

Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows	2019 $'000	2018 $'000
Within 1 year	**764**	760
Between 1 to 5 years	**2,232**	2,985
Total operating lease commitments	**2,996**	3,745

Note 1.2 Own-source revenue and gains

Own-source revenue	2019 $'000	2018 $'000
Note 1.2A: Sale of Goods and Rendering of Services		
Sale of goods	**1,719**	814
Rendering of services	**360**	454
Total sale of goods and rendering of services	**2,079**	1,268

Accounting Policy

Sale of goods and rendering of services

Revenue from the sale of goods is recognised when:

a) the risks and rewards of ownership have been transferred to the buyer; and

b) IHPA retains no managerial involvement or effective control over the goods.

Revenue from rendering of services is recognised by reference to the stage of completion at the reporting date. The revenue is recognised when the:

c) amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and

d) probably economic benefits associated with the transactions will flow to the Pricing Authority.

The stage of completion of contracts at the reporting date is determined by reference to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at the end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

	2019 $'000	2018 $'000
Note 1.2B: Resources received free of charge		
Departmental contribution received free of charge	**6,359**	5,799
Other resources received free of charge	**64**	62
Total other revenue	**6,423**	5,861

Accounting Policy

Resources received free of charge

Resources received free of charge are recognised as revenue when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense. Resources received free of charge are recorded as revenue.

	2019 $'000	2018 $'000
Note 1.2C: Other gains		
Reversal of restoration provision / make-good asset	**27**	186
Total other gains	**27**	186

	2019 $'000	2018 $'000
Note 1.2D: Revenue from Government		
Amounts from Department of Health	**15,487**	14,476
Total revenue from Government	**15,487**	14,476

Accounting Policy

Revenue from Government

Funding received or receivable from non-corporate Commonwealth entities is recognised as Revenue from Government by IHPA unless the funding is in the nature of an equity injection or a loan.

Financial position

This section analyses the IHPA's assets used to conduct its operations and the operating liabilities incurred as a result. Employee-related information is disclosed in the People and Relationships section.

Note 2.1 Financial assets

	2019 $'000	2018 $'000
Note 2.1A: Cash and Cash Equivalents		
Cash on hand or on deposit	**13,896**	13,712
Total cash and cash equivalents	**13,896**	13,712

Accounting Policy

Cash and cash equivalents

Cash is recognised at its nominal amount. Cash and cash equivalents includes:

a) cash on hand; and

b) demand deposits in bank accounts with an original maturity of 3 months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value.

	2019 $'000	2018 $'000
Note 2.1B: Trade and Other Receivables		
Other receivables		
GST receivable from the Australian Taxation Office	**281**	49
Other amounts receivable	**851**	31
Total other receivables	**1,132**	80
Total trade and other receivables (gross)	**1,132**	80
Less impairment allowance	**-**	-
Total trade and other receivables (net)	**1,132**	80
Trade and other receivables (net) expected to be recovered		
No more than 12 months	**1,132**	80
More than 12 months	**-**	-
Total trade and other receivables (net)	**1,132**	80

No amounts receivable are overdue.

Accounting Policy

Trade and other receivables

IHPA's financial assets are comprised of trade receivables and other receivables that are held for the purpose of collecting the contractual cash flows.

All of IHPA's financial assets are measured, and carried, at amortised cost.

Impairment

All assets were assessed for impairment as at 30 June 2019. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

Note 2.2 Non-financial assets including fair value measurement

Note 2.2A: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment, and Intangibles

	Leasehold improvements $'000	Plant and equipment $'000	Computer software $'000	Other intangibles $'000	Total $'000
As at 1 July 2018					
Gross book value	**324**	**352**	**966**	**288**	**1,930**
Accumulated depreciation, amortisation and impairment	**(32)**	**(76)**	**(411)**	**(211)**	**(730)**
Total as at 1 July 2018	**292**	**276**	**555**	**77**	**1,200**
Additions					
Purchase	**119**	**-**	**10**	**-**	**129**
Depreciation and amortisation	**(54)**	**(75)**	**(197)**	**(39)**	**(365)**
Disposals					
Non-cash consideration	**(151)**	**(70)**	**(189)**	**-**	**(410)**
Writeback of depreciation and other adjustments	**28**	**70**	**189**	**-**	**287**
Total as at 30 June 2019	**234**	**201**	**368**	**38**	**841**
Total as at 30 June 2019 represented by					
Gross book value	**292**	**282**	**787**	**288**	**1,649**
Accumulated depreciation, amortisation and impairment	**(58)**	**(81)**	**(419)**	**(250)**	**(808)**
Total as at 30 June 2019	**234**	**201**	**368**	**38**	**841**

No indicators of impairment were found for leasehold improvements, or property, plant and equipment or intangibles.

Note 2.2B: Fair Value Measurement

The following tables provide an analysis of assets and liabilities that are measured at fair value. The remaining assets and liabilities disclosed in the statement of financial position do not apply the fair value hierarchy.

The different levels of the fair value hierarchy are defined below.

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.

Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.

Level 3: Unobservable inputs for the asset or liability.

	Fair value measurements			
	2019 $'000	2018 $'000	Category (Level 1, 2 or 3)	Valuation technique(s) and inputs used[1]
Non-financial assets				
Leasehold improvements	**234**	292	3	Valuation technique is depreciated replacement costs. Inputs used are replacement cost new (price per square metre) and consumed economic benefit/obsolescence of asset.
Plant and equipment	**201**	276	2	Valuation technique is market approach and inputs used are adjusted market transactions.

[1]No change in valuation technique occurred during the period.

Accounting Policy

Property, plant and equipment, and intangibles

Assets are recorded at cost on acquisition except as stated below. The cost on acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor's accounts immediately prior to the restructuring.

Asset recognition threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases costing less than $5,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

Revaluations

Following initial recognition at cost, property, plant and equipment are carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted with sufficient frequency to ensure that the carrying amounts of assets did not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations depended upon the volatility of movements in market values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve, except to the extent that it reversed a previous revaluation decrement of the same asset class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets are recognised directly in the surplus/deficit, except to the extent that they reversed a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

Depreciation

Depreciable property, plant and equipment assets are written off to their estimated residual values over their estimated useful lives to the entity using, in all cases, the straight-line method of depreciation.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

	2019	2018
Leasehold improvements	Lease terms	Lease terms
Plant and equipment	3 to 6 years	3 to 6 years

Impairment

All assets were assessed for impairment at 30 June 2019. Where indications of impairment exist, the assets recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs of disposal and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the entity were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

Intangibles

The entity's intangibles comprise internally developed software for internal use. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the entity's software are 1 to 4 years (2018: 1 to 4 years).

All software assets were assessed for indications of impairment as at 30 June 2019.

Fair value measurement

IHPA tests the procedures of the valuation model as an internal management review at least once every 12 months (with a formal revaluation undertaken once every three years). If a particular asset class experiences significant and volatile changes in fair value (i.e. where indicators suggest that the value of the class has changed materially since the previous reporting period), that class is subject to specific valuation in the reporting period, where practicable, regardless of the timing of the last specific valuation.

Note 2.3 Payables

	2019 $'000	2018 $'000
Note 2.3A: Suppliers		
Trade creditors and accruals	**3,099**	2,174
Total suppliers	**3,099**	2,174

Amounts are expected to be settled in no more than 12 months.

	2019 $'000	2018 $'000
Note 2.3B: Other Payables		
Payable to Department of Health	**2**	-
Salaries and wages	**6**	2
Lease payable	**64**	5
Total other payables	**72**	7
Other payables to be settled		
No more than 12 months	**72**	2
More than 12 months	**-**	5
Total other payables	**72**	7

Note 2.4 Other provisions

	2019 $'000	2018 $'000
Restoration provision at the beginning of the financial period	**151**	186
Reversal of restoration provision on lease expiry or change in lease terms	**(151)**	(186)
Restoration provision on new lease arrangement	**-**	151
Total as at 30 June 2019	**-**	151

On the expiry of the office accommodation lease on 31 May 2018, a restoration provision of $0.186m was written back and replaced with a new restoration provision of $0.151m (with a matching make-good asset) on IHPA entering into a new lease. During 2019, it became reasonably certain that IHPA would exercise the 5-year option to extend the lease and as a result the restoration provision was not required under the terms of the lease.

People and relationships

This section describes a range of employment and post-employment benefits provided to our people and our relationships with other key people.

Note 3.1 Employee provisions

	2019 $'000	2018 $'000
Note 3.1A: Employee provisions		
Leave	**85**	76
Total employee provisions	**85**	76
Employee provisions expected to be settled		
No more than 12 months	**13**	12
More than 12 months	**72**	64
Total employee provisions	**85**	76

Accounting Policy

Employee provisions

Liabilities for short-term employee benefits and termination benefits expected within 12 months of the end of reporting period are measured at their nominal amounts.

Other long-term employee benefits are measured as net total of the present value of the defined benefit obligation at the end of the reporting period, minus the fair value at the end of the reporting period of plan assets (if any), out of which the obligations are to be settled directly.

Leave

The liability for employee benefits includes provision for annual leave and long service leave.

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the entity's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination. The estimate of the present value of the liability takes into account attrition rates, and pay increases through promotion and inflation.

Superannuation

The entity's staff are members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), or the PSS accumulation plan (PSSap), or other superannuation funds held outside the Australian Government.

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported in the Department of Finance's administered schedules and notes.

The entity makes employer contributions to the employees' defined benefit superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the Government. The entity accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions.

Note 3.2 Key management personnel remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any Pricing Authority member. The entity has determined the key management personnel to be the Chief Executive Officer and the Pricing Authority members.

Key management personnel remuneration

	2019 $'000	2018 $'000
Short-term employee benefits	**768**	737
Post-employment benefits	**54**	55
Other long-term benefits	**8**	20
Termination benefits	**-**	-
Total key management personnel remuneration expenses[1]	**830**	812

The total number of key management personnel that are included in the above table is 10 (2018: 12).

[1] The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Ministers whose remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the entity.

Note 3.3 Related party disclosures

Related party relationships

The entity is an Australian Government controlled entity. Related parties to this entity are the key management personnel as per Note 3.2 Key Management Personnel Remuneration and other Australian Government entities.

Transactions with related parties

Given the breadth of Government activities, related parties may transact with the Government sector in the same capacity as ordinary citizens. Such transactions include the payment or refund of taxes, receipt of a Medicare rebate or higher education loans. These transactions have not been separately disclosed in this note.

Giving consideration to relationships with related entities, and transactions entered into during the reporting period by the entity, it has been determined that there are no related party transactions to be separately disclosed.

Managing uncertainties

This section analyses how IHPA manages financial risks within its operating environment.

Note 4.1 Contingent assets and liabilities

Quantifiable contingencies

There were no quantifiable contingent assets or liabilities in this reporting period (2018: nil).

Unquantifiable contingencies

There were no unquantifiable contingent assets or liabilities in this reporting period (2018: nil).

Significant remote contingencies

There were no significant remote contingent assets or liabilities in this reporting period (2018: nil).

Accounting Policy

Contingent asset and liabilities

Contingent liabilities and contingent assets are not recognised in the statement of financial position but are reported in the notes. They may arise from uncertainty as to the existence of a liability or asset, or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain, and contingent liabilities are disclosed when settlement is greater than remote.

Note 4.2 Cash and financial instruments

	2019 $'000	2018 $'000
Note 4.2A: Cash and cash equivalents		
Cash at bank	**13,896**	13,712
Note 4.2B: Financial instruments (assets)		
Financial assets under AASB 139		
Loans and receivables		
Trade and other receivables		128
Less: Impairment allowance		-
Total loans and receivables		128
Financial assets under AASB 9		
Financial assets at amortised cost		
Trade and other receivables	**851**	
Less: Impairment allowance	**-**	
Total assets at amortised cost	**851**	
Note 4.2C: Financial instruments (liabilities)		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	**3,099**	2,174
Total financial liabilities measured at amortised cost	**3,099**	2,174

Accounting Policy

Cash and cash equivalents

Cash is recognised at its nominal amount.

Trade and other receivables

AASB 9 *Financial Instruments* (AASB 9) applies to IHPA from 1 July 2018 and replaces AASB 139 *Financial Instruments: Recognition and Measurement* (AASB 139).

Classification and measurement

The classification and measurement of IHPA's financial assets under AASB 9 is determined by its business model for managing its financial assets and the contractual cash flow characterisitcs of those assets. Financial assets are recognised when IHPA becomes a party to the contract and has a legal right to receive cash.

Financial assets

IHPA's financial assets are comprised of trade receivables and other receivables that are held for the purpose of collecting the contractual cash flows.

Under AASB 9, all of IHPA's financial assets are measured, and carried, at amortised cost.

Financial liabilities

IHPA's financial liabilities are measured, and carried, at amortised cost. Supplier and other payables are recognised to the extent that the goods or services have been received, irrespective of having been invoiced.

Impairment

AASB 9 requires IHPA to impair its financial assets by applying the 'expected credit losses' (ECL) model. IHPA has taken advantage of the practical expedient which allows the use of a Provision Matrix to calculate expected credit losses on trade receivables. IHPA has assessed the loss allowance for its financial assets at an amount equal to lifetime expected credit losses.

Due to the nature of IHPA's receivables, a nil loss allowance has been calculated. There is no impairment of IHPA's financial assets for 2018-19.

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Appendix B: Acronyms and abbreviations

ANAO	Australian National Audit Office
COAG	Council of Australian Governments
IHPA	Independent Hospital Pricing Authority
MoU	Memorandum of Understanding
NHCDC	National Hospital Cost Data Collection
NWAU	National Weighted Activity Unit
PGPA Act	*Public Governance, Performance and Accountability Act 2013*

Appendix C: Glossary

Activity based funding

A system for funding public hospital services based on the actual number of services provided to patients and the efficient cost of delivering those services. Activity based funding uses national classifications, cost weights and National Efficient Price to determine the amount of funding for each activity or service.

Australian Refined Diagnosis Related Groups

Australian Refined Diagnosis Related Groups are an Australian admitted patient classification system which provides a clinically meaningful way of relating a hospital's casemix to the resources required by the hospital. Each Australian Refined Diagnosis Related Group represents a class of patients with similar clinical conditions requiring similar hospital services. The classification categorises acute admitted patient episodes of care into groups with similar conditions and similar usage of hospital resources, using information in the hospital morbidity record such as the diagnoses, procedures and demographic characteristics of the patient.

Avoidable hospital readmissions

An avoidable hospital readmission occurs when a patient who has been discharged from hospital (index admission) is admitted again within a certain time interval, and the readmission:

- is clinically related to the index admission, and
- has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

The complete list of hospital acquired complications is available on the Australian Commission for Safety and Quality in Healthcare's website.

Back-casting

The process by which the effect of significant changes to the activity based funding classification systems or costing methodologies are reflected in the pricing model the year prior to implementation, for the calculation of Commonwealth Government funding for each activity based funding service category.

Block funding

A system of funding public hospital functions and services as a fixed amount based on population and previous funding.

Casemix

The number and type of patients treated in a hospital.

Council of Australian Governments (COAG)

The Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia.

The members include the Prime Minister, state and territory Premiers and Chief Ministers, and the President of the Australian Local Government Association. The role of COAG is to promote policy reforms that are of national significance, or which need coordinated action by all Australian governments.

Corporate Plan

The primary strategic planning document of a Commonwealth Government entity. It sets out the objectives, capabilities and intended results over a four-year period, in accordance with the entity's stated purposes. The Corporate Plan should provide a clear line of sight with the relevant annual performance statement, Portfolio Budget Statement and Annual Report.

Hospital acquired complication

A complication which occurs during a hospital stay such as falls, infections or pressure injuries.

Clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The complete list of hospital acquired complications is available on the Australian Commission for Safety and Quality in Healthcare's website.

National Efficient Cost

IHPA determines a National Efficient Cost for services that are not suitable for activity based funding, such as small rural hospitals. The National Efficient Cost determines the Australian Government contribution to block funded hospitals.

National Efficient Price

A base price calculated by IHPA as a benchmark to guide governments about the level of funding that would meet the average cost of providing acute care (admitted, emergency and outpatient) services in public hospitals across Australia. The National Efficient Price is based on the projected average cost of a National Weighted Activity Unit (NWAU) after the deduction of specified Commonwealth Government funded programs.

National Health Reform Act 2011

IHPA was established under the *National Health Reform Act 2011*. The *National Health Reform Act 2011* gave effect to the National Health Reform Agreement signed by the Australian Government and all states and territories in August 2011.

National Health Reform Agreement

The Agreement outlines the funding, governance and performance arrangements for the delivery of public hospital services in Australia. The Agreement was entered into by the Commonwealth Government and all states and territories in August 2011.

National Weighted Activity Unit (NWAU)

An NWAU is a measure of health service activity expressed as a common unit, against which the National Efficient Price is paid. It provides a way of comparing and valuing each public hospital service (whether it is an admission, emergency department presentation or outpatient episode), by weighting it for its clinical complexity.

The average hospital service is worth one NWAU. The most intensive and expensive activities are worth multiple NWAUs, and the simplest and least expensive are worth fractions of an NWAU.

Protective Security Policy Framework

The Protective Security Policy Framework provides policy, guidance and better practice advice for governance, personnel, physical and information security. The 36 mandatory requirements assist agency heads to identify their responsibilities to manage security risks to their people, information and assets.

Public Governance, Performance and Accountability Act 2013 (PGPA ACT)

The PGPA Act establishes a coherent system of governance and accountability for public resources, with an emphasis on planning, performance and reporting. The PGPA Act applies to all Commonwealth entities and Commonwealth companies.

Sentinel event

A sentinel event is a subset of adverse events that result in death or serious harm to the patient, such as surgical procedures involving the wrong body part or medication errors leading to death.

Work program

Each year IHPA consults on and publishes a work program for the year ahead. As prescribed in s225 of the *National Health Reform Act 2011*, the objectives of the IHPA Work Program are to: set out IHPA's work program for the coming year, and invite interested persons (including states and territories) to make submissions to the Pricing Authority about the work program up to 30 days after publication. IHPA Work Programs are available at **www.ihpa.gov.au/publications**.

Appendix D: Compliance index

The Independent Hospital Pricing Authority, as a corporate Commonwealth entity, has prepared this annual report under section 17BA of the Public Governance, Performance and Accountability Rule 2014, and section 46 of the *Public Governance, Performance and Accountability Act 2013*.

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Approval by the accountable authority	1
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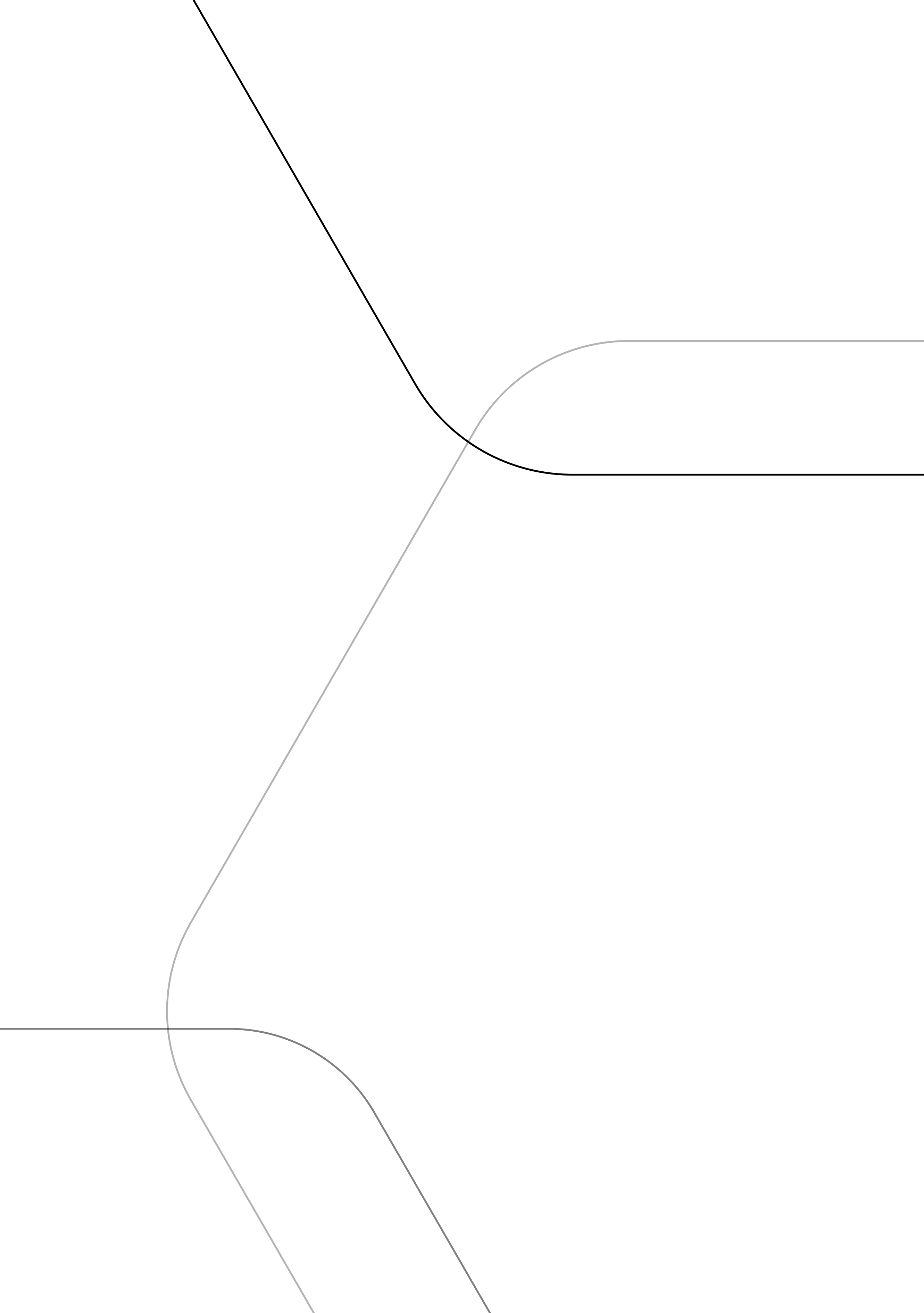

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