

Annual Report

2019–20

Independent Hospital Pricing Authority

About this report

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Online version

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Suggested citation: Independent Hospital Pricing Authority Annual Report 2019–20

Online ISSN: 2201–1862

Print ISSN: 2201–0718

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Letter of transmittal



Ref: D20-10829

Letter of transmittal

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

Dear Minister,

On behalf of the Independent Hospital Pricing Authority (IHPA), I am pleased to submit to you, for presentation to Parliament, the annual report and financial statements of IHPA for the financial year ended 30 June 2020.

The Annual Report 2019-20 has been prepared in accordance with the requirements of the *National Health Reform Act 2011*, the *Public Governance, Performance and Accountability Act 2013* and the Public Governance, Performance and Accountability Rule 2014.

The report's annual performance statements were prepared in accordance with the requirements of section 39 of the *Public Governance, Performance and Accountability Act*.

The report includes the agency's audited financial statements, as required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.

As required by section 10 of the Public Governance, Performance and Accountability Rule 2014, I certify that IHPA has in place appropriate measures to prevent, detect and manage the risk and incidents of fraud.

Yours sincerely,

James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

6 October 2020

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 2020, 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
2 October 2020

About IHPA

01

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 together to improve health outcomes for every Australian.

Addendum to the National Health Reform Agreement 2017–20

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

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

Under the 2017 Addendum, IHPA was 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.

National Partnership on COVID-19 Response

On 13 March 2020, the Commonwealth and all state and territory governments signed the National Partnership on COVID-19 Response, to provide financial assistance for the additional costs incurred by health services in responding to the COVID-19 pandemic.

IHPA has worked closely with the Administrator of the National Health Funding Pool to provide assistance in implementation of the National Partnership Agreement for COVID-19 response.

In order to implement the measures under this Agreement, IHPA developed the national activity based funding classifications and updated the new coding and classification systems for reporting COVID-19 in Australian hospitals, including emergency and non-admitted care.

Comprehensive guidelines were published on the [IHPA website](#) for hospitals to classify or report COVID-19 related episodes of care, so that testing for and treatment of COVID-19 could be accurately reported and tracked. Accurately capturing hospital activity associated with the COVID-19 outbreak is critical for other purposes, such as epidemiological studies.

IHPA also drafted the national costing and pricing guidelines for COVID-19, to ensure that the costs of responding to the pandemic are consistently captured across the country.

Addendum to the National Health Reform Agreement 2020–25

On 29 May 2020, the Commonwealth and all state and territory governments signed a new Addendum, which amends the National Health Reform Agreement for the period from 1 July 2020 to 30 June 2025.

The Addendum to the National Health Reform Agreement:

- maintains a commitment to activity based funding
- reaffirms the independence and functions of the national agencies such as IHPA, the National Health Funding Body and the Australian Commission on Safety and Quality in Health Care
- retains the 45 per cent Commonwealth funding contribution and the 6.5 per cent national growth cap
- continues to integrate safety and quality reforms into the pricing and funding of public hospital services, including the current arrangements for sentinel events and hospital acquired complications.

Key changes to current arrangements introduced in the Addendum include:

- IHPA is required to develop an updated methodology for pricing private patients in public hospitals that accounts for all hospital revenues, to ensure funding models are financially neutral with respect to all patients, regardless of whether patients elect to be private or public.
- IHPA is required to develop a pricing model for avoidable hospital readmissions for implementation from 1 July 2021, following approval from the Council of Australian Governments (COAG) Health Council.
- IHPA is required to shadow price for a period of two years, or a shorter period if agreed by the Commonwealth and majority of states, prior to implementation of new classifications or costing rules to mitigate the need for retrospective adjustments to the national funding model.
- High cost, highly specialised therapies will attract 50 per cent Commonwealth funding under the new nationally cohesive health technology assessment process, and these will be considered outside the 6.5 per cent national growth cap for a period of two years.
- IHPA is required to develop a funding methodology that does not penalise states undertaking trials of innovative models of care, for the COAG Health Council to approve by April 2021.

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.

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 agency 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**', p11).

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 COAG Heads of Agreement on Public Hospital Funding.

In 2017, all Australian governments signed an Addendum to the National Health Reform Agreement. Through this, parties committed to develop and implement reforms to improve health outcomes of Australians through funding and pricing approaches to safety and quality. These reforms are designed to improve patient outcomes in the public health system and decrease avoidable demand for public hospital services.

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

IHPA works together with the Australian Commission on Safety and Quality in Health Care to incorporate safety and quality measures into the determination of the national efficient price.

Under the Addendum 2017–20, 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 the 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 the 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 2017–20 Addendum required 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 analysing three options of funding adjustments to reduce avoidable hospital readmissions. These are being shadowed over a 24-month period.

Under the new 2020–25 Addendum, IHPA is required to develop a pricing model for avoidable hospital readmissions for the COAG Health Council’s approval for implementation from 1 July 2021.

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 and Minister Assisting the Prime Minister for the Public Service and Cabinet.

Ministerial directions and government policy orders

On 29 January 2020, IHPA received a Ministerial direction from the Hon. Greg Hunt MP, under section 226(1) of the *National Health Reform Act 2011*.

The direction requires that IHPA study existing and projected costs for Nationally Funded Centres and recommend options regarding:

- whether Nationally Funded Centres, individually and collectively, are more appropriately funded via activity based funding or block funding arrangements under the National Health Reform Agreement.
- the development and operation of cost models and pricing models for the Nationally Funded Centres, covering both existing and potential future services delivered under the program.

In issuing this direction, the Minister consulted with the COAG Health Council.

In compliance with the direction, IHPA has undertaken the requested study with states and territories and prepared an interim report for consideration of the Australian Health Ministers Advisory Council.

IHPA will prepare a final report for consideration of the COAG Health Council by no later than 31 January 2021.

Pricing for public hospital services

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 hospital services.

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

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.

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.

In 2019–20, 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.

Figure 1: National Efficient Price 2020–21



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, including mental health and subacute services, emergency department presentations and outpatient service events.



Classification

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

In activity based funding it is essential to understand the total costs involved in providing hospital services to a patient, and assign costs based on resource consumption. IHPA compiles the National Hospital Cost Data Collection annually. This information is used for developing the classification systems and for the national 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 accounted for in the classification system. For 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.ihoa.gov.au/what-we-do

Block funding

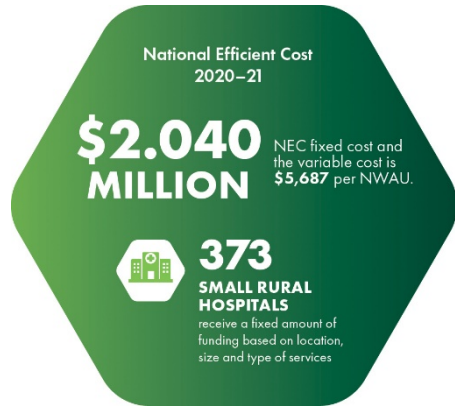
The [national efficient cost](#) underpins funding for services that are not suitable for activity based funding, such as:

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

The national efficient cost represents the average cost of Commonwealth funding contribution on a block grant basis for small rural hospitals.

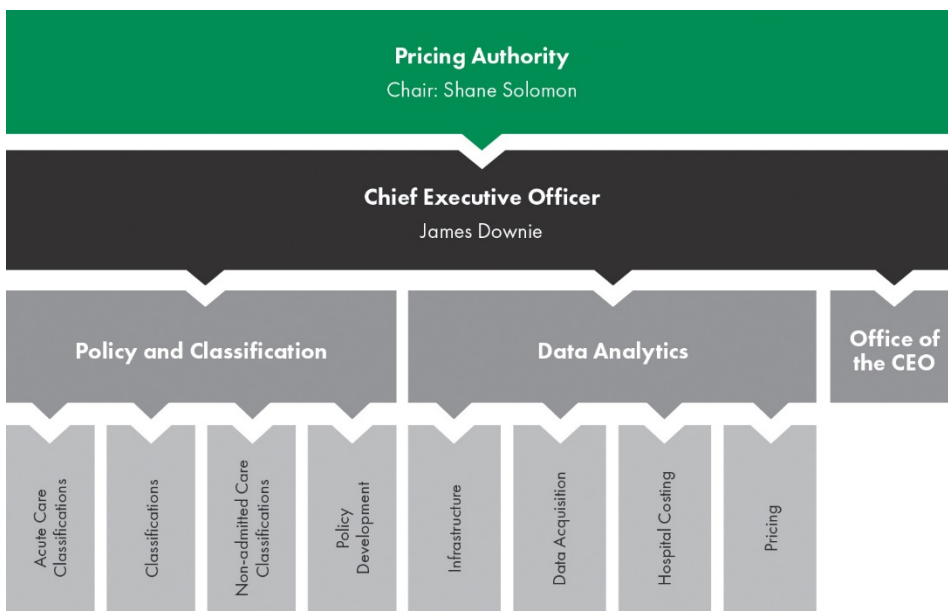
The national efficient cost is determined using the in-scope activity and expenditure data for hospitals to be block funded. For the 2020–21 national efficient cost, a new cost model based on a fixed-plus-variable structure has been introduced in consultation with states and territories. This new model has a more sophisticated approach in calculating block funding to better reflect the changes in activity delivered in small rural hospitals, and it ensures there is no disincentive for states to provide services in rural areas.

Figure 2: National Efficient Cost 2020–21



Organisational structure

Figure 3: IHPA's organisational structure as at 30 June 2020



The Pricing Authority is a corporate Commonwealth entity consisting of a Chair, Deputy Chair, and up to seven other members. See [p22](#) for more information.

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.

IHPA's office in Sydney is the only facility of the entity and the agency'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*.

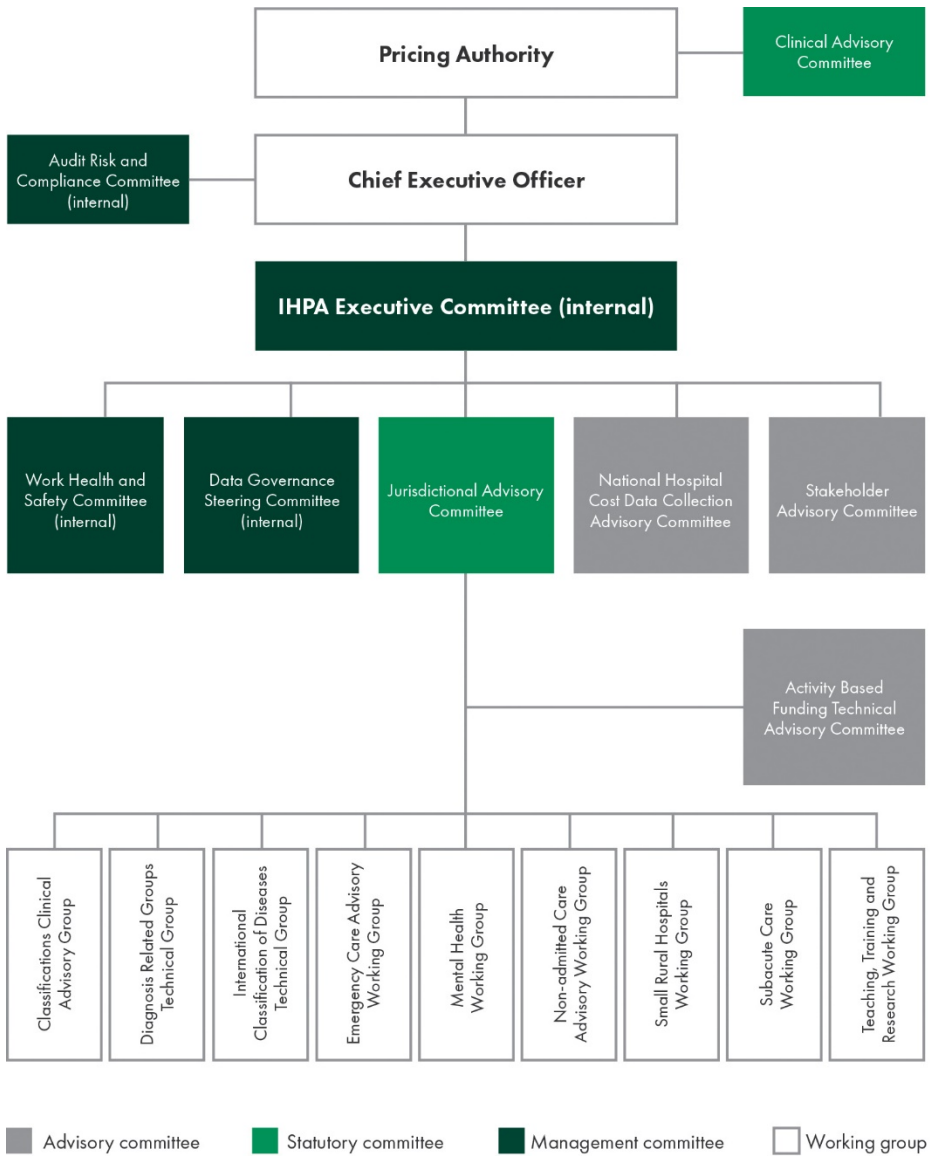
Other advisory committees and working groups have been established to assist IHPA in the delivery of its work program, pursuant to Part 4.12 of the *National Health Reform Act 2011*. These include:

- 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
- International Classification of Diseases Technical 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, which are regularly updated.

Figure 4: 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 2020, the Clinical Advisory Committee consists of 23 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 [p30](#).

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 and 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 12 occasions between 1 July 2019 and 30 June 2020.

Jurisdictional Advisory Committee members as of 30 June 2020:

- James Downie, Chair
- Rob Anderson (Western Australia)
- Lynne Cowan (South Australia)
- Toni Cunningham (Queensland)
- Peter O'Halloran (Australian Capital Territory)
- Denise Ferrier (Victoria)
- Nigel Lyons (New South Wales)
- Tania Rishniw (Commonwealth Government)
- Ross Smith (Tasmania)
- Stathi Tsangaris (Northern Territory)

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

Pricing Authority

02

Chair's welcome



I am pleased to present the Independent Hospital Pricing Authority's Annual Report for 2019–20.

As Chair of the Pricing Authority, it was a pleasure to lead IHPA to deliver another full work program last year. The COVID-19 pandemic also presented us with unique challenges.

New Addendum to the Health Reform Agreement 2020–25

In May 2020, all Australian governments signed an Addendum to the National Health Reform Agreement. This Addendum reaffirms all parties' commitment to improving health outcomes for Australians and reducing the demand for avoidable public hospital services. To these ends, it maintains the commitment to activity based funding, and focuses further on reforms for improved safety and quality, health innovation and coordinated care.

The decision to maintain the existing funding arrangement into 2020–25 shows confidence in activity based funding, with an emphasis on efficient pricing.

Still, there is much work to do. I believe the key changes in the new agreement—including pricing of private patients in public hospitals, pricing adjustments for avoidable hospital readmissions, nationally cohesive new health technology assessment, and innovative funding models—will help shape strategies that will improve health outcomes for all Australians.

Response to COVID-19

The National Partnership on COVID-19 Response was signed in March 2020, ensuring additional health service funding to cover the national response to the outbreak. It enabled the Commonwealth, states and territories to respond rapidly to COVID-19 and control the spread of the virus.

In order to implement the measures under the Agreement, IHPA updated the national activity based funding classifications and data reporting requirements, and published rules for coding and costing COVID-19 episodes of care.

Stable and sustainable rate of growth

IHPA published its ninth National Efficient Price Determination and eighth National Efficient Cost Determination for public hospital services in 2020–21, which involved extensive consultation with jurisdictions and stakeholders. The Determinations are critical in deciding the Commonwealth funding contribution to public hospital services. They also provide a benchmark for the efficient cost of providing these services, and enable a stable and sustainable rate of growth in public hospital costs. (See **Figures 5 and 6**)

Delivering safe, high-quality and efficient health care

Working with the Australian Commission on Safety and Quality in Health Care and other stakeholders, IHPA continues to incorporate safety and quality into the pricing and funding of public hospital services, to improve health outcomes, and decrease avoidable demand for public hospital services. IHPA started a two-year shadow period in 2019–20 to assess funding options to reduce avoidable hospital readmissions.

Valuable stakeholder partnerships and collaboration

IHPA continues to build many strategic and trusted partnerships we share with all Australian governments, peak bodies and associations. Engaging with and listening to our key stakeholders is a vital part of meeting our priorities.

I would also like to highlight the contributions made by our Clinical Advisory Committee. Their advice is essential to the decisions we make.

Commendations

This year the Pricing Authority said farewell to Dr Michael Walsh, who was an inaugural Authority member. I want to thank Michael for supporting the Pricing Authority with his invaluable contributions and expert knowledge. I congratulate Ms Jennifer Williams on her appointment as Deputy Chair of the Authority—a testament to her abilities and commitment to the Authority. I also welcome Ms Jenny Richter, who brings many years of health administration and nursing expertise to the Pricing Authority. Thank you to all Pricing Authority members who provided professional vision and guidance throughout 2019–20.

On behalf of the Pricing Authority, I would like to commend James Downie, Chief Executive Officer, for his steady and insightful leadership. I also acknowledge the IHPA staff for their constant commitment to deliver a successful program of work in a timely manner especially in this challenging situation.

Looking ahead

In an evolving environment, I am confident that we continue to build a solid foundation to 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

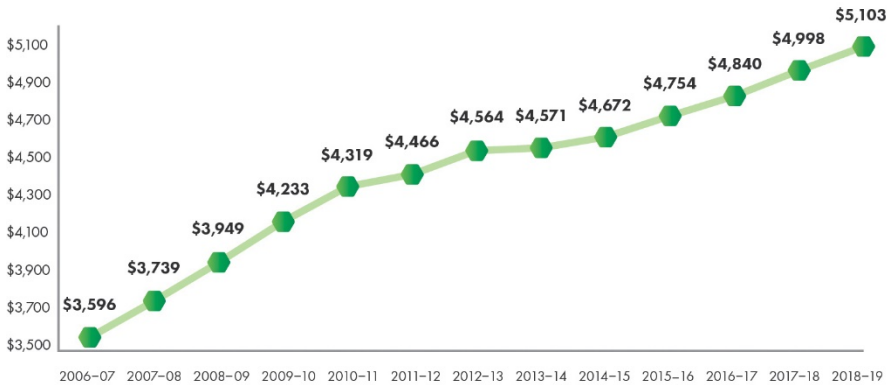
2 October 2020

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 5 indicates a significant reduction in the rate of growth in costs since 2011–12, to a sustained growth rate of 1.9 per cent.

Figure 5: Cost per National Weighted Activity Unit (NWAU)



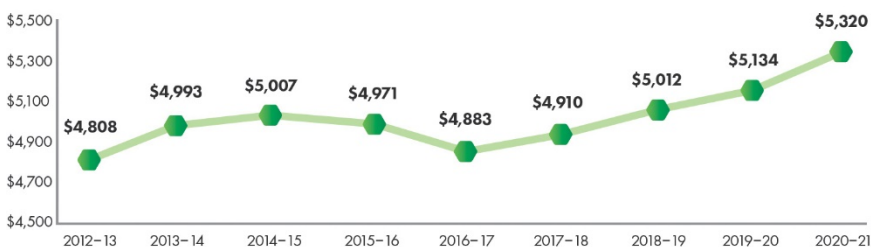
National efficient price

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 6, 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 occur, to enable the fair calculation of the Australian Government’s growth funding.

Figure 6: National Efficient Price 2012–2020



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.





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.

Ms Jennifer Williams (Deputy Chair)

Jennifer Williams is a Non-Executive Director and holds a number of board positions including Chair of Northern Health and Chair of Yooralla.

Her other board appointments are with the Australian Medical Research Advisory Board, 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.

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 the Chair of the Tasmanian Economic Regulator.

Associate Professor Bruce Chater

Associate Professor Bruce Chater is Head of the Mayne Academy 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, Chair 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.

Ms Jenny Richter

Jenny Richter holds directorships with the South Australian Health and Medical Research Institute, The Cancer Council SA and the Southern Adelaide Local Health Network, where she also chairs the Clinical Governance Board Sub-Committee.

Jenny Richter is an independent consultant and has previously held a number of executive roles, including five years as Deputy Chief Executive for SA Health and more recently as CEO of Central Adelaide Local Health Network.

Jenny's experience in the health sector commenced as a registered nurse, following which she gained significant leadership experience in areas of hospital and health service planning and performance both in Australia and the United Kingdom.

Jenny is a graduate of the Australian Institute of Company Directors, a Fellow of the Australasian College of Health Service Management and a Fellow of the Royal College of Nursing Australia. She has a Master of Business Administration, a Graduate Diploma in Health Administration and a Bachelor of Arts.

Dr Kate Taylor

Dr Kate Taylor is the Chief Executive Officer and Founder of Oculo, an online platform to connect eye care professionals and their patients. 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 public-private 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.

Meetings of the Pricing Authority 2019–20

Table 1: Meetings of the Pricing Authority 2019–20

The Pricing Authority met on nine occasions between 1 July 2019 and 30 June 2020. The Chief Executive Officer, James Downie, as the accountable authority, attended all nine meetings.

Member	Meetings eligible	Meetings attended
Mr Shane Solomon (Chair)	9	9
Ms Jennifer Williams (Deputy Chair)	9	9
Mr Glenn Appleyard	9	6
A/Prof Bruce Chater	9	9
Ms Prudence Ford	9	9
Prof Jane Hall	9	9
Dr Kate Taylor	9	8
Dr Michael Walsh	6	5
Ms Jenny Richter	4	4

Mr Jim Birch resigned from the Authority effective 30 June 2019 and Ms Jennifer Williams was appointed as Deputy Chair effective from 1 February 2020.

Ms Jenny Richter was appointed on 1 February 2020, and Dr Michael Walsh resigned effective of 1 April 2020.

IHPA 2019–20

Overview

03

CEO's year in review



2019–20 proved to be a busy year for IHPA, with unexpected challenges posed by the COVID-19 outbreak, in addition to our regular work program.

These 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.

Responding to COVID-19

IHPA has worked closely with the Administrator of the National Health Funding Pool to provide assistance in implementing the National Partnership Agreement for COVID-19 response.

A key part of this has been the drafting of the national costing and pricing guidelines for COVID-19, to ensure that the costs of responding to the pandemic are consistently captured across the country.

It is critical for the healthcare system to accurately capture data on the patients treated during the pandemic.

I am proud that IHPA has been able to respond swiftly to develop new coding and classification systems for reporting COVID-19 within the Australian health care system and guidelines for hospitals when coding COVID-19 events.

We also provided guidance to states and territories and public hospitals on how the costs of treating COVID-19 patients should be captured. This will provide an extremely rich set of data that will be useful to policy makers and health researchers in the future.

Key highlights

In May 2020, all Australian governments signed the Addendum to the National Health Reform Agreement 2020–25, which commences on 1 July 2020. The Agreement maintains a commitment to activity based funding and reaffirms the role of IHPA.

Our work program for 2019–20 continued to be shaped by the safety and quality measures agreed by all Australian governments in 2017. We continued reforms to improve safety and quality, including reducing avoidable hospital admissions, and working for the provision of safe, high-quality care cross the Australian public hospital system.

As well as our primary function of setting the National Efficient Price and National Efficient Cost, IHPA continued to develop and refine the many classifications, counting and costing systems and funding models, which underpin the national activity based funding system. We also used data and research to inform our best practices and performance.

In 2019–20, we continued development of a new version of the Australian National Subacute and Non-acute Patient Classification, and the Australian Mental Health Care Classification, and continued to build reporting systems to support the implementation of the new Australian Teaching and Training Classification.

Investing in partnerships

IHPA's achievements throughout 2019–20 would not have been 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. IHPA undertook a national consultation in 2019, in order to determine a best practice development cycle for the acute care classifications.

Commendation

I take this opportunity to acknowledge the contributions of the Pricing Authority. I also wish to thank the Clinical Advisory Committee for their expert guidance to deliver a clinically-relevant annual program of work.

There have been several changes to the Pricing Authority team this year. I would like to thank Dr Michael Walsh, who resigned from the Pricing Authority this year. Michael was an inaugural member of the Authority, serving since 2012. We have benefitted greatly from his expertise during his tenure. I wish to congratulate Ms Jennifer Williams who has been appointed as Deputy Chair of the Authority. I am also very pleased to welcome Ms Jenny Richter to the Pricing Authority.

This year, IHPA invested in technological support for our staff. This proved to be critical in maintaining the required work performance efficiently and enabled a smooth transition to working from home when the government's COVID-19 restrictions were in place.

I extend my thanks to all the IHPA staff for their support and commitment once again, especially during the challenging times we have faced during the coronavirus outbreak. I am delighted to be leading an agency that strives for excellence in delivering its purpose.

Year ahead

IHPA will continue to work closely with all jurisdictions and the national agencies to progress the implementation of the long-term, key principles outlined in the 2020–25 Addendum, and continue to support funding arrangements under the National Partnership Agreement on COVID-19 Response.

In the year ahead, IHPA will continue its strategic direction as outlined in its Corporate Plan 2020–21 to ensure that we continue to deliver our core purpose.



James Downie
Chief Executive Officer, IHPA
2 October 2020

2019–20 highlights

Some of the key achievements from IHPA's Work Program for 2019–20 include:

July

- Implementation of the Eleventh Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and the Australian Coding Standards (ACS)

August

- Completion of a global horizon scan to identify alternative approaches to health care funding that could be applied in the Australian context

December

- Pricing Framework for Australian Public Hospital Services 2020–21 published
- The fundamental review of the national efficient price completed

February

- National Hospital Cost Data Collection, Public Hospital Cost Report, Round 22 (financial year 2017–18) published

March

- National Efficient Price and National Efficient Cost Determinations for 2020–21 published
- Publication of shadow price weights for admitted mental health care using the Australian Mental Health Care Classification Version 1.0

April

- National Hospital Cost Data Collection, Private Hospital Cost Report, Round 22 (financial year 2017–18) published

May

- Consultation on IHPA's draft Work Program 2020–21
- Rules for coding and reporting COVID-19 episodes published

June

- Three Year Data Plan 2020–21 to 2022–23 published
- Finalisation of the Mental Health Phase of Care Clinical Refinement Project
- IHPA's Work Program 2020–21 published

Clinical Advisory Committee

04

Letter from the Chair



It is a privilege to chair the Clinical Advisory Committee and to present our Annual Report for 2019–20.

The Clinical Advisory Committee is a multidisciplinary group whose members have extensive clinical knowledge and skills across a wide range of areas.

The committee draws on this expertise and experience to provide advice in relation to IHPA's program of work.

In 2019–20, the committee provided ongoing input to the Pricing Framework for Australian Public Hospital Services 2019–20, ensuring the Framework's policies remained clinically relevant. The committee provided advice to allow IHPA to ensure National Efficient Price and National Efficient Cost Determinations for 2020–21 were fit for purpose.

This year we played a critical role in providing clinical input about the options for pricing and funding for the safety and quality reforms introduced in the 2017 Addendum to the National Health Reform Agreement. This included the continued participation of the joint working party with the Australian Commission on Safety and Quality in Health Care.

The committee provided clinical advice on IHPA's three proposed funding options for reducing avoidable hospital readmissions. The committee will continue to advise IHPA in this area, as the agency works on further analysis.

In 2019–20, the Clinical Advisory Committee continued its work advising on classification systems. The committee also contributed to the final review of the processes involved in the acute care classifications development.

Under the National Partnership on COVID-19 Response, IHPA issued classification and reporting rules to accurately capture COVID-19 episodes of care and COVID-19 related hospital activity on a nationally consistent basis. Committee members provided feedback to ensure that the rules and advice were clinically sound.

The committee members continued to promote the WRITEitRIGHT® mobile application, which enables accurate clinical documentation by clinicians and health information managers.

My sincere thanks to my fellow committee members for their meaningful contribution and thoughtful consideration of the complex and at times highly technical issues over the past year. I deeply appreciate their commitment to improving efficiency, accountability and transparency across the public healthcare system.

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 2019–20.

I look forward to continuing to lead the work of the Clinical Advisory Committee in 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
2 October 2020

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, and 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:

- to advise the Pricing Authority in relation to developing and specifying classification systems for health care and other services provided by public hospitals
- to advise the Pricing Authority in relation to matters that:
 - relate to the functions of the Pricing Authority, and
 - are referred to the Clinical Advisory Committee by the Pricing Authority
- 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. The Remuneration Tribunal determines remuneration.

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 2019–20

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

Clinical Advisory Committee meetings 2019–20

5 August 2019

4 November 2019

30 March 2020

2019–20 highlights

In 2019–20, the Clinical Advisory Committee supported IHPA’s work program to deliver the following key achievements:

- The Pricing Framework for Australian Public Hospital Services 2020–21
- IHPA’s determination of the National Efficient Price and National Efficient Cost for 2020–21
- Feedback on the national activity based funding classifications and updated the new coding and classification systems for reporting COVID-19 in Australian hospitals, including emergency and non-admitted care
- Advice on the final report on the consultation and review to develop new versions of the classifications for admitted acute care
- 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.

Annual Performance Statements

05

Introductory Statement

I, James Downie, as the accountable authority of the Independent Hospital Pricing Authority (IHPA), present the 2019–20 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 2019–20

Table 3: Relationship between 2019–20 Portfolio Budget Statements, IHPA Corporate Plan 2019–20 and the 2019–20 Annual Report Performance Statement

2019–20 Portfolio Budget Statements	
<p>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</p>	
<p>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</p>	
2019–20 Corporate Plan	
<p>Purpose To determine the National Efficient Price and the National Efficient Cost for public hospital services</p>	
<p>Strategic objective 1 Perform IHPA pricing functions</p>	<p>Activity 1: Perform IHPA Pricing Functions</p>
<p>Strategic objective 2 Refine and develop hospital activity classification systems</p>	<p>Activity 2: Refine and develop national classification systems</p>
<p>Strategic objective 3 Refine and improve hospital costing</p>	<p>Activity 3: Refine and improve hospital costing</p>
<p>Strategic objective 4 Determine data requirements and collect data</p>	<p>Activity 4: Develop hospital data requirements and collect data</p>
<p>Strategic objective 5 Resolve disputes on cost-shifting and cross-border issues</p>	<p>Activity 5: Resolve disputes on cost-shifting and cross-border issues</p>
<p>Strategic objective 6 Independent and transparent decision-making and engagement with stakeholders</p>	<p>Activity 6: Independent and transparent decision-making and engagement with stakeholders</p>

Table 4: Summary of Performance for 2019–20

1. Perform IHPA pricing functions	
Publish the Pricing Framework for Australian Public Hospital Services 2019–20 by 31 December 2019	Delivered
Publish the National Efficient Price and National Efficient Cost Determinations by 31 March 2020	Delivered
Undertake a fundamental review of the methodology underpinning the National Efficient Price	Delivered
Undertake a review of 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	Delivered
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
Continue data collection for the Australian Teaching and Training Classification	Delivered
Complete development work on the Australian Emergency Care Classification system for emergency care services	Delivered
Further refine the Australian Mental Health Care Classification	Delivered
Continue development of the admitted Australian National 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
Continue development of AR-DRGs V11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition	Ongoing
3. Refine and improve hospital costing	
Maintain national costing standards	Ongoing
Ensure effective collection and processing of costing information to support activity based funding outcomes	Delivered
Produce informative and authoritative information of hospital costs	Delivered
Evaluate compliance with new aspects incorporated in the Australian Hospital Patient Costing Standards Version 4.0.	Delivered

4. Develop hospital data requirements and collect data

Publish the Three Year Data Plan 2020–21 — 2022–23 Delivered

Develop the process for the collection of Individual Healthcare Identifiers as part of national data sets Ongoing

Further development of the Secured Data Management System Ongoing

Collection of jurisdictional submission for quarterly activity based funding activity data Delivered

Publish a data compliance report on a quarterly rolling basis Delivered

Maintain and continue to develop the National Benchmarking Portal, including promoting access for all local health networks Delivered

5. Resolve disputes on cost-shifting and cross-border issues

Publish an updated Cost-shifting and Cross-border Dispute Resolution Framework Delivered

6. Independent and transparent decision-making and engagement with stakeholders

IHPA held 78 meetings with the 18 committees and working groups, to provide expert advice and to ensure the transparency and integrity of the organisation. Ongoing

Results

Results against performance criteria are as follows:

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 2019–20, 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 2019.
2. Publish the National Efficient Price and National Efficient Cost Determinations by 31 March 2020.
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

- 2019–20 Corporate Plan — Strategy 1
- 2019–20 Portfolio Budget Statement Program 1.1

Results against performance criteria

1. The Pricing Framework for Australian Public Hospital Services 2020–21 was published on 5 December 2019.
2. The National Efficient Price and National Efficient Cost Determinations 2020–21 were published on 2 March 2020.
3. The range between the 50th and 90th percentile decreased from \$1,070 in 2016–17 to \$926 in 2016–17, representing a reduction of \$144.
4. During 2019–20, 82.63% 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 0.63% compared to June 2019.

Table 5: 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%
2019–20	82.63%

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, admitted subacute and non-acute, 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 2019, IHPA commissioned a review of the processes involved in the development of the activity based funding classifications for acute care. The review highlighted some key opportunities for improvement, including a move to a three-year development cycle. IHPA has started to implement opportunities highlighted by the review, including the extended development cycle. IHPA continued to further develop the classifications for admitted subacute and non-acute care, non-admitted patient care and mental health care.

In addition, to implement the measures under the National Partnership on COVID-19 Response, IHPA updated the national activity based funding classifications and data reporting requirements to accommodate the emerging situation with COVID-19. Accurately capturing hospital activity associated with the COVID-19 outbreak will also be critical for other purposes, such as epidemiological studies.

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 admitted subacute and non-acute 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 International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, Australian Classification of Health Interventions, Australian Coding Standards, Twelfth Edition, for implementation on 1 July 2022. Collectively this classification system is known as ICD-10-AM/ACHI/ACS.
7. Continue development work on the Australian Refined Diagnosis Related Groups Version 11.0 (AR-DRG V11.0) for release mid-2022 and implementation 1 July 2023.

Source

- 2019–20 Corporate Plan — Strategy 2
- 2019–20 Portfolio Budget Statement Program 1.1

Results against performance criteria

1. In 2019–20, the Mental Health Phase of Care Clinical Refinement project final report was published. The report captured clinical evidence and initial recommendations of proposed mental health phase of care options. IHPA continues to work with jurisdictions to refine the Australian Mental Health Care Classification.
2. IHPA released the Australian Teaching and Training Classification Version 1.0 in 2018–19. During 2019–20, IHPA continued to build the reporting systems to collect 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 and feedback from public consultation. This classification places greater emphasis on patient factors such as diagnosis and complexity. It also has greater capacity to incorporate additional factors that drive patient complexity and cost. The Australian Emergency Care Classification is being shadow priced for 2020–21.

4. Development of a new version of the admitted Australian National Subacute and Non-Acute Patient classification continued in 2019–20 using reported data and clinical advice.

The development project involves a thorough review of all current variables and thresholds, as well as assessments of potential new variables to make the end classes more clinically relevant and resource homogenous.

5. Work on the development of the new Australian Non-Admitted Care Classification continued. During 2019–20, IHPA finalised project set-up and site selection, and commenced data collection for a national non-admitted costing study to inform the development of the classification. Data collection for the main costing study commenced in October 2019 but has been suspended due to the need for hospitals to focus on the response to the COVID-19 outbreak. It is anticipated that the data collection will recommence when activity undertaken by hospital non-admitted services has normalised and refined service delivery models have been established.

6. The ICD-10-AM/ACHI/ACS Eleventh Edition was implemented on 1 July 2019. Development of ICD-10-AM/ACHI/ACS Twelfth Edition commenced in July 2019, for implementation on 1 July 2022.

AR-DRG V10.0 was released in 2019 and used to price admitted acute episodes of care from 1 July 2020. Development of AR-DRG V11.0 commenced in 2019 for release in 2022.

Refinements to the ICD-10-AM/ACHI/ACS and AR-DRG classifications 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. Continue to maintain the Australian Hospital Patient Costing Standards (AHPCS) Version 4.0.
2. Ensure effective collection and processing of costing information to support activity based funding outcomes.
3. Produce informative and authoritative information of hospital costs.
4. Evaluate compliance with new aspects incorporated in the AHPCS Version 4.0.

Source

- 2019–20 Corporate Plan — Strategy 3
- 2019–20 IHPA Work Program — Activity 5(a)

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 23 (financial year 2019–20) data set was collected.
3. In 2019–20, IHPA adapted the NHCDC report into a set of accessible infographics and thematic articles designed to reach a wider audience.
4. The annual NHCDC Independent Financial Review evaluated jurisdictions' compliance with new aspects of the AHPCS.

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 2020.
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. Maintain internal data assessment and compliance.
5. Receive assurance from jurisdictions regarding data quality/accuracy.
6. Protect privacy and ensure data security.

Source

- 2019–20 Corporate Plan — Strategy 4
- 2019–20 Portfolio Budget Statement Program 1.1

Result against performance criteria

1. The updated Three Year Data Plan was published on the IHPA website in June 2020.
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.
6. IHPA will continue to develop the secure data management system to support its core technical functions, while ensuring the current high standards of data security are maintained.

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

- 2019–20 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 July 2019.
2. In 2019–20, 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

- 2019–20 Corporate Plan
- 2019–20 Work Program

Results against performance criteria

1. In 2019–20 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 two public consultation processes in 2019–20, each in accordance with the *National Health Reform Act 2011*. These included:
 - a. Pricing Framework for Australian Public Hospital Services 2020–21 (July 2019)
 - b. IHPA Work Program 2020–21 (May 2020)
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 194 inbox enquiries during the reporting period. IHPA responded to 51% within two weeks and to 37% of those on the day of receipt.

**Table 6: Response rate to enquiries
1 July 2019 – 30 June 2020**

Total request	Same day response	1–7 days	7–14 days	15+ days
194	72	82	17	23

5. Delegates at the Activity Funding Conference in 2019 indicated a biennial rather than annual conference would be better suited with their personal and organisational needs. IHPA has taken their feedback on board and decided to hold the event biennially. The next conference will be held in May 2021.

Analysis

IHPA has had another productive year, meeting its performance criteria and deliverables in IHPA’s corporate plan and work program for 2019–20, as well as meeting the requirements as part of the National Partnership on COVID-19 Response.

The IHPA Work Program 2019–20 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.ihipa.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 staged roll-out of our new approach to pricing and funding for safety and quality.

IHPA’s work towards pricing and funding for safety and quality, as per the 2017 Addendum, continued in 2019–20.

As outlined in the Pricing Framework 2019–20, IHPA commenced a 24-month shadow period, on 1 July 2019, to analyse three funding options, based on an approved list of conditions from the Australian Commission on Safety and Quality in Health Care, to assist in reducing avoidable hospital readmissions.

IHPA worked closely with a team of clinicians on the three proposed funding options for reducing avoidable hospital readmissions, which contributes to improving hospital systems, rather than applying

penalties related to certain patients or patient groups who fall into specific risk factor categories. IHPA will continue to develop a risk adjustment model for each readmission condition, such as pressure injuries, infections, and surgical complications, based on identified risk factors.

IHPA worked closely with the Administrator of the National Health Funding Pool to provide assistance in implementation of the National Partnership Agreement for COVID-19 response.

A key part of this has been the drafting of the national costing and pricing guidelines for COVID-19, to ensure that the costs of responding to the pandemic are consistently captured across the country.

IHPA updated classification systems for the Australian hospital system to ensure accurate data on the number of patients being treated in the hospital system, including the details of their diagnosis and treatments received.

IHPA also modified the national pricing model for activity based funding to ensure that the possible costs of treating patients diagnosed with COVID-19 were recognised.

The National Efficient Price and National Efficient Cost Determinations for 2019–20 continue to demonstrate the benefits of activity based funding in reducing costs. IHPA completed the independent fundamental review of the national efficient price in 2019, recommending that no significant changes were required to the national pricing model and that it was found to be fit-for-purpose.

Management and Accountability

06

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 with 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, which is reviewed annually.

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 internal control processes. Where new risks emerge, resources are assigned to understand and manage those risks. They are reviewed bi-annually or as required.

Tactical risks are managed through a decision-based risk management tool, which 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.

During the period of this annual report, IHPA closely monitored and managed the operational and technical risks associated with the COVID-19 pandemic.

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'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.
- 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*.

¹ Mr Butterworth resigned as Chair of the Audit, Risk and Compliance Committee with effect from 31 December 2019.

Financial authorization

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.

During the reporting period, members of the Audit, Risk and Compliance Committee comprised:

- Mr Robert Butterworth, Chair and Independent member ¹
- Ms Angela Diamond, Chair and Independent member ²
- Mr Alan Bansemer, Independent member
- Mr Glenn Appleyard, Member of the Pricing Authority.

² Ms Diamond was appointed as Chair of the Audit, Risk and Compliance Committee with effect from 15 February 2020.

Table 7: Details of Audit, Risk and Compliance Committee during the reporting period (2019–2020)

The IHPA Audit, Risk and Compliance Committee met on three occasions between 1 July 2019 and 30 June 2020. The Chief Executive Officer, James Downie, as the accountable authority, attended all three meetings.

Member Name	Qualifications, knowledge, skills and experience	Number of meetings attended/ total number of meetings	Total annual remuneration
Robert Butterworth³	<p>Robert Butterworth is a retired Australian Public Service (APS) officer. His career in the APS spanned 32 years including 23 years at Senior Executive Service (SES) level and 17 years as a Band 2. Robert has held SES positions in the three central agencies of Finance, Prime Minister and Cabinet and the Treasury, and in the Environment Department. He has also worked in the Canadian and Papua New Guinea civil services. His most recent position was Division Manager of the Asset Sales and Shareholder Division in the Department of Finance and Deregulation.</p> <p>Robert was Chair of the Comcover Advisory Board and Chair of the Audit and Risk Management Committee of the Migration Review and Refugee Review Tribunals. In addition, he has also been a member of the Building and Construction Code Monitoring Group and the Sydney Harbour Federation Trust Audit and Risk Management Committee.</p> <p>Robert also undertakes short-term contract work assignments in the APS, including assurance reviews for the Department of Finance.</p> <p>Robert has an Honours degree in Economics from the University of Sydney and a Graduate Diploma in Economics from the Australian National University.</p>	1/1	\$2,000
Angela Diamond⁴	<p>Angela Diamond has held several senior finance positions within the public service including First Assistant Secretary Financial Performance and Management at the Department of Defence and is currently the Chief Financial Officer for Services Australia.</p> <p>Angela has a Bachelor of Commerce from the Australian National University and is a Certified Practising Accountant (CPA).</p>	3/3	Nil
Glenn Appleyard	<p>Glenn Appleyard was a member of the Australian Accounting Standards Board from 1 January 2003 to 31 December 2011.</p> <p>Glenn has held several senior positions within the public service including Deputy Secretary in the Tasmanian and Victorian Departments of Treasury and Finance, Regional Director for the Australian Bureau of Statistics in Tasmania.</p> <p>He was a member of the Commonwealth Grants Commission for 11 years and was the Chair of the Tasmanian Economic Regulator.</p>	2/3	\$4,000

³ Mr Butterworth resigned as Chair of the Audit, Risk and Compliance Committee with effect from 31 December 2019.

⁴ Ms Diamond was appointed as Chair of the Audit, Risk and Compliance Committee with effect from 15 February 2020. In accordance with government policy, Ms Diamond did not receive any remuneration as a member of the IHPA Audit, Risk and Compliance Committee as she is employed by a Commonwealth Entity.

Member Name	Qualifications, knowledge, skills and experience	Number of meetings attended/ total number of meetings	Total annual remuneration
	<p>Glenn has been a member of the Independent Hospital Pricing Authority since 2012.</p> <p>Glenn has a Bachelor of Economics from the University of Tasmania and is a Graduate Member of the Australian Institute of Company Directors.</p>		
Alan Bansemer	<p>Alan Bansemer has over 35 years' experience in the health sector, including six years as the West Australian Health Commissioner and eight years as the Deputy Secretary to the Commonwealth Department of Human Services and Health (as it then was).</p> <p>Alan has chaired a number of committees including the Medicare Schedule Review Board and General Practice Consultative Committee. In addition, he has served as a member of numerous health advisory committees including the Australian Health Ministers' Advisory Council, Health Insurance Commission (now Medicare Australia) and the Australian Institute of Health and Welfare.</p> <p>Alan has a bachelor's degree in economics from the University of Adelaide and postgraduate diploma in business administration from the South Australian Institute of Technology.</p>	2/3	\$4,000

Fraud control plan

IHPA's fraud control plan is recognised as a critical internal tool used to mitigate the act and consequences of authorised 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, and is reviewed annually or as required.

Inter-agency financial activity

During the 2019–20 financial year, IHPA received shared services resourcing from the Department of Health.

The Department of Health charged IHPA \$374,000 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 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.

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.

Ongoing and Non-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 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 8: Ongoing seconded employees 2020

Classification	Male			Female			Total
	Full-time	Part-time	Total	Full-time	Part-time	Total	
SES	0	0	0	2	0	2	2
EL2	7	0	7	5	2	7	14
EL1	8	0	8	8	2	10	18
APS Level 6	5	0	5	7	2	9	14
APS Level 5	0	0	0	1	0	1	1
Total	20	0	20	23	6	29	49

Table 9: Ongoing seconded employees 2019

Classification	Male			Female			Total
	Full-time	Part-time	Total	Full-time	Part-time	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

Table 10: Non-ongoing seconded employees 2020

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

Table 11: Non-ongoing seconded employees 2019

Classification	Male			Female			Total
	Full-time	Part-time	Total	Full-time	Part-time	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

Key management personnel

Table 12: Information about remuneration for key management personnel (KMP)

Name	Position title	Short term benefits				Post-employment benefits			Other long-term benefits			Total remuneration \$
		Base salary \$	Bonuses \$	Other benefits and allowances \$	Superannuation Contributions \$	Long service leave \$	Other long term benefits \$	Termination benefits \$				
Glenn Appleyard ¹	Pricing Authority member	37,741	-	-	5,776	-	-	-	-	-	43,517	
Bruce Chater	Pricing Authority member	31,741	-	-	3,015	-	-	-	-	-	34,756	
James Downie	Chief Executive Officer	455,225	-	-	20,935	8,665	-	-	-	-	484,825	
Prudence Ford	Pricing Authority member	31,741	-	-	3,015	-	-	-	-	-	34,756	
Jane Hall	Pricing Authority member	31,741	-	-	3,015	-	-	-	-	-	34,756	
Shane Solomon	Pricing Authority member (Chair)	85,627	-	-	8,135	-	-	-	-	-	93,762	
Jenny Richter ²	Pricing Authority member	12,647	-	-	1,201	-	-	-	-	-	13,848	
Kate Taylor	Pricing Authority member	31,741	-	-	3,015	-	-	-	-	-	34,756	
Michael Walsh ³	Pricing Authority member	24,415	-	-	2,319	-	-	-	-	-	26,734	
Jennifer Williams ⁴	Pricing Authority member (Deputy Chair)	31,741	-	-	3,015	-	-	-	-	-	34,756	
Total		774,360	-	-	53,441	8,665	-	-	-	-	836,466	

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 sifting fees

² Jenny Richter was appointed from 1 February 2020

³ Michael Walsh resigned as at 1 April 2020

⁴ Jennifer Williams was appointed as Deputy Chair from 1 February 2020

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.

During the period, the Chief Executive Officer completed the Australian Institute of Company Directors (AICD) Company Directors course. IHPA supported individuals to attend conferences and training events that assisted them to acquire and develop skills used in their work. In 2019–20, IHPA's training investment averaged \$3,520 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.

**Table 13: Details of accountable authority during the reporting period
current report period (2019–2020)**

				Period as the accountable authority or member		
Name	Qualifications of the Accountable Authority	Experience of the Accountable Authority	Position Title	Date of Commencement	Date of cessation	Number of meetings of the board of the company
James Downie	Masters of Business Administration; Bachelor of Engineering, Metallurgical Engineering	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.	Chief Executive Officer	1 September 2016	31 August 2021	N/A

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. He receives regular performance feedback via the Pricing Authority meetings.

During the period, the Chief Executive Officer completed the Australian Institute of Company Directors (AICD) Company Directors course.

Work health and safety

In 2019–20, 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, and provided additional support to staff working from home during the COVID-19 pandemic.

In 2019–20, 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 2019–20, IHPA commissioned no advertising that must be reported under s. 311A of the *Commonwealth Electoral Act 1918*.

Financial Management

07

Financial statements

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Independent Hospital Pricing Authority Financial Statements 2019–20

For the year ended 30 June 2020

Statement by the Chief Executive Officer and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2020 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
2 October 2020



Chris Miljak
Chief Financial Officer
2 October 2020

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 2020:

- (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 2020 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 as at 30 June 2020 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 (including Independence Standards)* (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.

Other information

The Accountable Authority is responsible for the other information. The other information comprises the information included in the annual report for the year ended 30 June 2020 but does not include the financial statements and my auditor's report thereon.

My opinion on the financial statements does not cover the other information and accordingly I do not express any form of assurance conclusion thereon.

In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

GPO Box 707 CANBERRA ACT 2601
38 Sydney Avenue FORREST ACT 2603
Phone (02) 6203 7300 Fax (02) 6203 7177

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.

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
2 October 2020

Primary financial statements

Statement of comprehensive income

for the period ended 30 June 2020

	Notes	2020 \$'000	2019 \$'000	Original Budget \$'000
NET COST OF SERVICES				
EXPENSES				
Employee benefits	1.1A	7,983	6,763	7,126
Suppliers	1.1B	13,224	17,034	15,754
Depreciation and amortisation	2.2A	1,323	365	465
Finance costs	1.1C	75	-	-
Losses from the disposal of assets		152	-	-
Total expenses		22,757	24,162	23,345
OWN-SOURCE INCOME				
Own-source revenue				
Sale of goods and rendering of services	1.2A	804	2,079	900
Interest		56	177	220
Resources received free of charge	1.2B	7,722	6,423	7,201
Total own-source revenue		8,582	8,679	8,321
Gains				
Other gains	1.2C	-	27	-
Total gains		-	27	-
Total own-source income		8,582	8,706	8,321
Net cost of services		14,175	15,456	15,024
Revenue from Government	1.2D	15,024	15,487	15,024
Surplus		849	31	-
Total comprehensive surplus		849	31	-

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

Budget Variances Commentary

Statement of Comprehensive Income

Total expenses of \$22.757m were \$0.588m lower than the budgeted amount of \$23.345m. The main driver was lower supplier expenses of \$2.530m which was partially offset by higher employee benefits of \$0.857m and, depreciation and amortisation expense of \$0.858m.

Supplier expenses were lower than budget primarily due to a greater proportion of projects being managed in-house which resulted in net savings and deferred program activity arising from state and territory hospital resources being reassigned to manage the COVID-19 pandemic.

Employee benefits were higher than budget due to a greater number of staff compared to budget assumptions and, depreciation and amortisation was higher primarily due to the exclusion of depreciation on right-of-use assets in the budget assumptions. Note that estimates from the adoption of AASB 16 Leases were excluded from budget assumptions consistent with Department of Finance advice provided to Commonwealth entities.

Total own source income of \$8.582m was \$0.261m greater than the budgeted amount of \$8.321m, primarily due to higher resources received free of charge of \$0.521m which was partially offset by lower sales of goods and rendering of services of \$0.096m, and interest of \$0.164m. Resources received free of charge exceeded the budget primarily due to the recovery of higher employee expenses. Sales of goods and rendering of services were lower than budget due to fewer sales of licences relating to the Australian Refined Diagnosis Related Groups classification systems and interest was lower than budget due to larger than anticipated reduction in interest rates.

Statement of financial position

as at 30 June 2020

	Notes	2020 \$'000	2019 \$'000	Original Budget \$'000
ASSETS				
Financial assets				
Cash and cash equivalents	2.1A	14,119	13,896	13,085
Trade and other receivables	2.1B	199	1,132	80
Total financial assets		14,318	15,028	13,165
Non-financial assets				
Buildings	2.2A	6,112	-	-
Leasehold improvement	2.2A	1,686	234	1,433
Plant and equipment	2.2A	2	201	214
Computer software and other intangibles	2.2A	177	406	343
Other - prepayments		161	155	153
Total non-financial assets		8,138	996	2,143
Total assets		22,456	16,024	15,308
LIABILITIES				
Payables				
Suppliers	2.3A	2,416	3,099	2,264
Other payables	2.3B	12	72	60
Total payables		2,428	3,171	2,324
Interest bearing liabilities				
Lease liabilities	2.4A	6,433	-	-
Total interest bearing liabilities		6,433	-	-
Provisions				
Employee provisions	3.1A	101	85	96
Other provisions		-	-	151
Total provisions		101	85	247
Total liabilities		8,962	3,256	2,571
Net assets		13,494	12,768	12,737
EQUITY				
Contributed equity		400	400	400
Asset revaluation reserve		-	74	88
Retained surplus		13,094	12,294	12,249
Total equity		13,494	12,768	12,737

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

Budget Variances Commentary

Statement of Financial Position

Total assets of \$22.456m were \$7.148m higher than the budget of \$15.308m primarily due to the recognition of right-of-use assets in relation to the lease of office space of \$6.112m. The cash balance was also \$1.034m higher than budget primarily due to the current year surplus.

Total liabilities of \$8.962m were \$6.391m higher than the budget of \$2.571m primarily due to the recognition of lease liabilities in relation to the lease of office space of \$6.433m. Note that estimates from the adoption of AASB 16 Leases were excluded from budget assumptions consistent with Department of Finance advice provided to Commonwealth entities.

Total equity of \$13.494m was \$0.757m higher than the budget of \$12.737m primarily due to the current period surplus noting that the budget is derived on a break-even assumption.

Statement of changes in equity

for the period ended 30 June 2020

Notes	2020 \$'000	2019 \$'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	74	88	88
Transfer to retained earnings			
From disposal of revalued assets	(74)	(14)	-
Closing balance as at 30 June	-	74	88
RETAINED EARNINGS			
Opening balance			
Balance carried forward from previous period	12,294	12,249	12,294
Adjustment for changes to accounting standards			
Adjustment on initial application of AASB 16	(123)	-	-
Transfer from asset revaluation reserve			
From disposal of revalued assets	74	14	-
Comprehensive income			
Surplus for the period	849	31	-
Closing balance as at 30 June	13,094	12,294	12,294
TOTAL EQUITY			
Opening balance			
Balance carried forward from previous period	12,768	12,737	12,737
Equity movements during the period			
Adjustment on initial application of AASB 16	(123)	-	-
Surplus for the period	849	31	-
Closing balance as at 30 June	13,494	12,768	12,737

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

Budget Variances Commentary

Statement of Changes in Equity

Total equity of \$13.494m was \$0.757m higher than the budget of \$12.737m primarily due to the current period surplus noting the budget is derived on a break-even assumption. IHPA has applied AASB 16 Leases using the modified retrospective approach and applied adjustments on initial application against retained earnings in accordance with the standard.

Cash flow statement

for the period ended 30 June 2020

	Notes	2020 \$'000	2019 \$'000	Original Budget \$'000
OPERATING ACTIVITIES				
Cash received				
Receipts from government		15,714	14,797	15,024
Sale of goods and rendering of services		1,025	1,994	963
Interest		67	179	220
Net GST received		1,681	1,237	1,425
Total cash received		18,487	18,207	17,632
Cash used				
Employees		(835)	(768)	(850)
Suppliers		(14,988)	(17,223)	(16,367)
Interest payments on lease liabilities		(75)	-	-
Total cash used		(15,898)	(17,991)	(17,217)
Net cash from / (used by) operating activities		2,589	216	415
INVESTING ACTIVITIES				
Cash used				
Purchase of computer software		-	(10)	-
Purchase of leasehold improvements		(1,728)	(22)	(1,300)
Total cash used		(1,728)	(32)	(1,300)
Net cash from / (used by) investing activities		(1,728)	(32)	(1,300)
FINANCING ACTIVITIES				
Cash used				
Principal payments of lease liabilities		(638)	-	-
Total cash used		(638)	-	-
Net cash from / (used by) financing activities		(638)	-	-
Net increase in cash held		223	184	(885)
Cash and cash equivalents at the beginning of the reporting period		13,896	13,712	13,970
Cash and cash equivalents at the end of the reporting period	2.1A	14,119	13,896	13,085

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 \$14.119m was \$1.034m higher than the budgeted amount of \$13.085m primarily due to the current 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
- 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 for 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), 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 2019–20

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

COVID-19 pandemic impacts

Due to state and territory hospital resources being reassigned to manage the COVID-19 pandemic, some forecast expenditure relating to the non-admitted costing study has been deferred until such time resources become available. There were no other financial impacts from the pandemic.

New 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 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 <i>Revenue from Contracts with Customers</i>	No impact
AASB 1058 <i>Income of Not-for-Profit Entities</i>	No impact
AASB 16 <i>Leases</i>	On adoption of AASB 16, IHPA recognised right-of-use assets and lease liabilities in relation to office space, which had previously been classified as an operating lease. As a result finance costs (representing an interest charge on the lease liability using the incremental borrowing rate as at the date of initial application) have been recognised for the first time and will decrease over the term term. Further information on the application of AASB 16 <i>Leases</i> and the impact on transition is provided below.

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 periods are not expected to have a future material financial impact on IHPA's financial statements.

Application of AASB 16 Leases

On the 1 July 2019, IHPA adopted AASB 16 using the modified retrospective approach, under which the cumulative effect of initial application is recognised in retained earnings at 1 July 2019. Accordingly the comparative information presented for 2019 is not restated, that is, it is presented as previously reported under AASB 117 and related interpretations.

Impact on transition

On transition to AASB 16, IHPA recognised additional right-of-use assets and lease liabilities and reduced lease payable to nil, recognising the difference in retained earnings. The impact on transition is summarised below:

	1 July 2019 \$'000
Increase in Right-of-Use assets — office space (Buildings)	6,884
Increase in lease liabilities	7,071
Reduction in lease payable	64
Reduction in retained earnings	123

The following table reconciles IHPA's minimum lease commitments disclosed in IHPA's 30 June 2019 annual financial statements to the amount of lease liabilities recognised on 1 July 2019:

	1 July 2019 \$'000
Minimum operating lease commitment at 30 June 2019	2,996
Plus: Effect of extension options reasonably certain to be exercised	4,450
Undiscounted lease payments	7,446
Less: Effect of discounting using the incremental borrowing rate as at the date of initial application	(375)
Lease liabilities recognised at 1 July 2019	7,071

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 the financial statements

Financial performance

This section analyses the financial performance of IHPA for the year ended 30 June 2020.

Note 1.1 Expenses

	2020	2019
	\$'000	\$'000
Note 1.1A: Employee Benefits		
Wages and salaries	527	545
Superannuation		
Defined contribution plans	61	60
Leave and other entitlements	267	267
Wages and salaries for staff provided by Department of Health	7,128	5,891
Total employee benefits	7,983	6,763

Accounting Policy

Employee benefits

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

	2020	2019
	\$'000	\$'000
Note 1.1B: Suppliers		
Goods and services supplied or rendered		
Consultants	4,244	7,330
Contractors	3,955	3,932
IT services	3,764	2,750
Travel	211	371
Training	168	170
Publishing materials	175	512
Legal and audit expenses	179	200
Conferences and seminars	158	633
Other	367	381
Total goods and services supplied or rendered	13,221	16,279
Goods supplied	307	658
Services rendered	12,914	15,621
Total goods and services supplied or rendered	13,221	16,279
Other suppliers		
Operating lease rentals in connection with minimum lease payments	-	751
Workers' compensation expenses	3	4
Total other suppliers	3	755
Total suppliers	13,224	17,034

Leasing commitments

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

	2020	2019
	\$'000	\$'000
Note 1.1C: Finance Costs		
Interest on lease liabilities (office space lease)	75	-
Total finance costs	75	-

The Entity has applied AASB 16 Leases using the modified retrospective approach and therefore the comparative information has not been restated and continues to be reported under AASB 117. Refer to Overview section for accounting policy on leases.

Note 1.2 Own-source revenue and gains

	2020	2019
	\$'000	\$'000
OWN-SOURCE REVENUE		
Note 1.2A: Sale of Goods and Rendering of Services		
Sale of goods	683	1,719
Rendering of services	121	360
Total sale of goods and rendering of services	804	2,079

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:

- a. amount of revenue, stage of completion and transaction costs incurred can be reliably measured, and
- b. probably economic benefits associated with the transactions will flow to IHPA.

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.

	2020	2019
	\$'000	\$'000
Note 1.2B: Resources received free of charge		
Departmental contribution received free of charge	7,657	6,359
Other resources received free of charge	65	64
Total other revenue	7,722	6,423

Accounting Policy

Revenue 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

	2020	2019
	\$'000	\$'000
Note 1.2C: Other gains		
Reversal of restoration provision / make-good asset	-	27
Total other gains	-	27

	2020	2019
	\$'000	\$'000
Note 1.2D: Revenue from Government		
Amounts from Department of Health	15,024	15,487
Total revenue from Government	15,024	15,487

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

	2020	2019
	\$'000	\$'000
Note 2.1A: Cash and Cash Equivalents		
Cash on deposit	14,119	13,896
Total cash and cash equivalents	14,119	13,896

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.

	2020	2019
	\$'000	\$'000
Note 2.1B: Trade and Other Receivables		
Other receivables		
GST receivable from the Australian Taxation Office	187	281
Other amounts receivable	12	851
Total other receivables	199	1,132
Total trade and other receivables (gross)	199	1,132
Less impairment allowance	-	-
Total trade and other receivables (net)	199	1,132
Trade and other receivables (net) expected to be recovered		
No more than 12 months	199	1,132
More than 12 months	-	-
Total trade and other receivables (net)	199	1,132

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 2020. 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

	Buildings \$'000	Leasehold improvement \$'000	Plant and equipment \$'000	Computer software and other intangibles \$'000	Total \$'000
As at 1 July 2019					
Gross book value	-	292	282	1,075	1,649
Accumulated depreciation, amortisation and impairment	-	(58)	(81)	(669)	(808)
Total as at 1 July 2019	-	234	201	406	841
Recognition of right-of-use asset on initial application of AASB 16	6,884	-	-	-	6,884
Adjusted total as at 1 July 2019	6,884	234	201	406	7,725
Additions					
Purchase	-	1,728	-	-	1,728
Depreciation and amortisation	-	(276)	(46)	(229)	(551)
Depreciation on right-of-use assets	(772)	-	-	-	(772)
Disposals					
Non-cash consideration	-	(173)	(276)	(288)	(737)
Writeback of depreciation and other adjustments	-	173	123	288	584
Total as at 30 June 2020	6,112	1,686	2	177	7,977
Total as at 30 June 2020 represented by					
Gross book value	6,884	1,847	6	787	9,524
Accumulated depreciation, amortisation and impairment	(772)	(161)	(4)	(610)	(1,547)
Total as at 30 June 2020	6,112	1,686	2	177	7,977
Carrying amount of right-of-use assets	6,112	-	-	-	6,112

No indicators of impairment were found for 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			Valuation technique(s) and inputs used ¹
	2020 \$'000	2019 \$'000	Category (Level 1,2 or 3)	
Non-financial assets				
Leasehold improvements	1,686	234	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	2	201	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:

	<u>2020</u>	<u>2019</u>
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 2020. 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 (2019: 1 to 4 years). All software assets were assessed for indications of impairment as at 30 June 2020.

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

	2020	2019
	\$'000	\$'000
Note 2.3A: Suppliers		
Trade creditors and accruals	2,416	3,099
Total suppliers	2,416	3,099

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

Note 2.3B: Other Payables		
Payable to Department of Health	2	2
Salaries and wages	10	6
Lease payable	-	64
Total other payables	12	72

Other payables to be settled		
No more than 12 months	12	72
More than 12 months	-	-
Total other payables	12	72

Note 2.4 Interest bearing liabilities

	2020	2019
	\$'000	\$'000
Note 2.4A: Lease liabilities		
Lease liability (office space)	6,433	-
Total lease liabilities	6,433	-
Lease liabilities expected to be settled		
No more than 12 months	677	-
More than 12 months	5,756	-
Total lease liabilities	6,433	-

IHPA has applied AASB 16 Leases using the modified retrospective approach and therefore the comparative information has not been restated and continues to be reported as an operating lease expense under AASB 117. Refer to Overview section for accounting policy on leases.

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

	2020 \$'000	2019 \$'000
Note 3.1A: Employee provisions		
Leave	101	85
Total employee provisions	101	85
Employee provisions expected to be settled		
No more than 12 months	16	13
More than 12 months	85	72
Total employee provisions	101	85

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 is reported in the table below:

	2020	2019
	\$'000	\$'000
Short-term employee benefits	774	768
Post-employment benefits	53	54
Other long-term benefits	9	8
Termination benefits	-	-
Total key management personnel remuneration expenses¹	836	830

The total number of key management personnel that are included in the above table is 10 (2019: 10).

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 (2019: nil).

Unquantifiable contingencies

There were no unquantifiable contingent assets or liabilities in this reporting period (2019: nil)

Significant remote contingencies

There were no significant remote contingent assets or liabilities in this reporting period (2019: 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

	2020	2019
	\$'000	\$'000
Note 4.2A: Cash and cash equivalents		
Cash on deposit	14,119	13,896
Note 4.2B: Financial instruments (assets)		
Financial assets at amortised cost		
Trade and other receivables	12	851
Less: Impairment allowance	-	-
Total assets at amortised cost	12	851
Note 4.2C: Financial instruments (liabilities)		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	2,416	3,099
Total financial liabilities measured at amortised cost	2,416	3,099

Accounting Policy

Cash and cash equivalents

Cash is recognised at its nominal amount.

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 characteristics of those assets.

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. 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. Lease liabilities are measured using the effective interest method.

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 2019-20.

Appendices

08

Appendix A:

Figures and Tables

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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 – *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 the 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 Commonwealth 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 Commonwealth 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.

Shadow pricing

Shadow pricing is the indicative or likely cost of services.

Clause A40 of the National Health Reform Agreement requires IHPA to consider transitional arrangements when developing new activity based funding classification systems or costing methodologies.

This includes shadowing the pricing of new classifications, costing methodologies or adjustments, when appropriate. Shadow pricing enables states and territories to understand and assess the impact of a new approach on the level and distribution of funding to local hospital networks.

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*.

PGPA Rule Reference	Part of Report		Description	Requirement
17BE	Contents of annual report			
17BE(a)	Legislation	3	Details of the legislation establishing the body	Mandatory
17BE(b)(i)	Who we are	5	A summary of the objects and functions of the entity as set out in legislation	Mandatory
17BE(b)(ii)	Who we are	5	The purposes of the entity as included in the entity's corporate plan for the reporting period	Mandatory
17BE(c)	Responsible Minister	9	The names of the persons holding the position of responsible Minister or responsible Ministers during the reporting period, and the titles of those responsible Ministers	Mandatory
17BE(d)	Ministerial directions and government policy orders	10	Directions given to the entity by the Minister under an Act or instrument during the reporting period	If applicable, mandatory
17BE(e)	Ministerial directions and government policy orders	10	Any government policy order that applied in relation to the entity during the reporting period under section 22 of the Act	If applicable, mandatory
17BE(f)	N/A		Particulars of non-compliance with: (a) a direction given to the entity by the Minister under an Act or instrument during the reporting period, or (b) a government policy order that applied in relation to the entity during the reporting period under section 22 of the Act	If applicable, mandatory
17BE(g)	Annual performance statements	38-51	Annual performance statements in accordance with paragraph 39(1)(b) of the Act and section 16F of the rule	Mandatory

PGPA Rule Reference	Part of Report		Description	Requirement
17BE(h), 17BE(i)	N/A		A statement of significant issues reported to the Minister under paragraph 19(1)(e) of the Act that relates to non-compliance with finance law and action taken to remedy non-compliance	If applicable, mandatory
17BE(j)	The accountable authority	61	Information on the accountable authority, or each member of the accountable authority, of the entity during the reporting period	Mandatory
17BE(k)	Organisational structure	14	Outline of the organisational structure of the entity (including any subsidiaries of the entity)	Mandatory
17BE(ka)	Ongoing and Non-ongoing Employees	57-59	<p>Statistics on the entity's employees on an ongoing and non-ongoing basis, including the following:</p> <p>(a) statistics on full-time employees</p> <p>(b) statistics on part-time employees</p> <p>(c) statistics on gender</p> <p>(d) statistics on staff location</p>	Mandatory
17BE(l)	Organisational structure	57	Outline of the location (whether or not in Australia) of major activities or facilities of the entity	Mandatory
17BE(m)	Key corporate governance practices	53-56	Information relating to the main corporate governance practices used by the entity during the reporting period	Mandatory
17BE(n), 17BE(o)	N/A		<p>For transactions with a related Commonwealth entity or related company where the value of the transaction, or if there is more than one transaction, the aggregate of those transactions, is more than \$10,000 (inclusive of GST):</p> <p>(a) the decision-making process undertaken by the accountable authority to approve the entity paying for a good or service from, or providing a grant to, the related Commonwealth entity or related company, and</p> <p>(b) the value of the transaction, or if there is more than one transaction, the number of transactions and the aggregate of value of the transactions</p>	If applicable, mandatory

PGPA Rule Reference	Part of Report	Description	Requirement
17BE(p)	N/A	Any significant activities and changes that affected the operation or structure of the entity during the reporting period	If applicable, mandatory
17BE(q)	N/A	Particulars of judicial decisions or decisions of administrative tribunals that may have a significant effect on the operations of the entity	If applicable, mandatory
17BE(r)	N/A	Particulars of any reports on the entity given by: (a) the Auditor-General (other than a report under section 43 of the Act), or (b) a Parliamentary Committee, or (c) the Commonwealth Ombudsman, or (d) the Office of the Australian Information Commissioner	If applicable, mandatory
17BE(s)	N/A	An explanation of information not obtained from a subsidiary of the entity and the effect of not having the information on the annual report	If applicable, mandatory
17BE(t)	N/A	Details of any indemnity that applied during the reporting period to the accountable authority, any member of the accountable authority or officer of the entity against a liability (including premiums paid, or agreed to be paid, for insurance against the authority, member or officer's liability for legal costs)	If applicable, mandatory
17BE(ta)	Key management personnel	60 Information about executive remuneration	Mandatory
17BF	Disclosure requirements for government business enterprises		
17BF(1)(a)(i)	N/A	An assessment of significant changes in the entity's overall financial structure and financial conditions	If applicable, mandatory
17BF(1)(a)(ii)	N/A	An assessment of any events or risks that could cause financial information that is reported not to be indicative of future operations or financial conditions	If applicable, mandatory
17BF(1)(b)	N/A	Information on dividends paid or recommended	If applicable, mandatory

PGPA Rule Reference	Part of Report	Description	Requirement
17BF(1)(c)	N/A	<p>Details of any community service obligations the government business enterprise has including:</p> <p>(a) an outline of actions taken to fulfil those obligations, and</p> <p>(b) an assessment of the cost of fulfilling those obligations</p>	If applicable, mandatory
17BF(2)	N/A	A statement regarding the exclusion of information on the grounds that the information is commercially sensitive and would be likely to result in unreasonable commercial prejudice to the government business enterprise	If applicable, mandatory

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