IHPA

IHPA Work Program and Corporate Plan

2021–22

Draft for Public Consultation

IHPA Work Program and Corporate Plan 2021–22 – DRAFT

Contents

I am pleased to present the Independent Hospital Pricing Authority's Work Program and Corporate Plan 2021–22 for the reporting periods 2021–22 to 2023–24.

The Independent Hospital Pricing Authority was established under the National Health Reform Act 2011 to implement national activity based funding for Australian public hospital services, where hospitals are funded for the number and complexity of patients they treat. The National Hospital Reform Agreement is the key mechanism for the transparency, governance and financing of Australia's public hospital system. Through this Agreement the Commonwealth Government contributes funds to the states and territories for public hospital services. On 29 May 2020, all Australian governments signed the Addendum to National Hospital Reform Agreement 2020–2025.

IHPA has a leading role in developing a nationally consistent and effective activity based funding system. IHPA classifies hospital activity and each year delivers a national efficient price for activity based funded services, and national efficient cost. The price and cost are informed by relevant expertise and best practice, submissions to government, continuity and predictability of costs, safety and quality, reasonable access, the range of hospitals and variables affecting the actual cost of providing health care services, and effectiveness, efficiency and financial sustainability. The price and cost are the basis for health funding from the Commonwealth.

James Downie

Chief Executive Officer, Independent Hospital Pricing Authority
Accountable Authority

Abbreviations and acronyms

ABF	Activity based funding
ACHI	Australian Classification of Health Interventions
ACS	Australian Coding Standards
AECC	Australian Emergency Care Classification
AHPCS	Australian Hospital Patient Costing Standards
AMHCC	Australian Mental Health Care Classification
ANACC	Australian Non-Admitted Care Classification
AN-SNAP	Australian National Subacute and Non-Acute Patient classification
AR-DRG	Australian Refined Diagnosis Related Groups
ATTC	Australian Teaching and Training Classification
CHC	Council of Australian Governments Health Council
COVID-19	Coronavirus Disease 2019
HAC	Hospital acquired complication
HSPC	Health Services Principal Committee
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
IHI	Individual Healthcare Identifier
IHPA	Independent Hospital Pricing Authority
Jurisdictions	Commonwealth, states and territories
LHN	Local Hospital Network
MHPoC	Mental health phase of care
NBP	National Benchmarking Portal
NEC	National efficient cost
NEP	National efficient price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NWAU	National Weighted Activity Unit
SDMS	Secured Data Management System
The Act	*National Health Reform Act 2011*
The Addendum	Addendum to the National Health Reform Agreement 2020-2025
The Commission	Australian Commission on Safety and Quality in Health Care
The Pricing Authority	Board of the Independent Hospital Pricing Authority

1. Introduction

The Independent Hospital Pricing Authority (IHPA) Work Program and Corporate Plan 2021–22 has been prepared in accordance with the requirements of section 225 of the *National Health Reform Act 2011* (the Act) and section 35(1)(b) *Public Governance, Performance and Accountability Act 2013* for the reporting periods 2021–22 to 2023–24.

1.1 Background

IHPA is an independent Commonwealth authority established under Commonwealth legislation as part of the National Health Reform Agreement (NHRA) reached by the Council of Australian Governments in August 2011. The NHRA sets out the intention of the Commonwealth and state and territory governments to work in partnership to improve health outcomes for all Australians.

IHPA's role is to:

- determine the national efficient price for health care services provided by public hospitals where the services are funded on an activity basis
- determine the efficient cost for health care services provided by public hospitals where the services are block funded
- publish these determinations, and other information, in a report each year for the purpose of informing decision makers in relation to the funding of public hospitals.

IHPA promotes improved efficiency in, and access to, public hospital services by:

- providing independent advice to governments in relation to the efficient costs of such services
- developing and implementing robust systems to support activity based funding for such services.

1.2 Purpose

The Work Program and Corporate Plan 2021–22 sets out the deliverables for the coming year. As prescribed in section 225 of the Act, IHPA invites interested persons (including states and territories) to make submissions about its work program.

The aim of publishing and calling for public submissions on the Work Program and Corporate Plan 2021–22 are to:

- enhance focus on the equitable funding of public hospitals
- improve efficiency, accountability and transparency across the public health care system
- drive financial sustainability of public hospital services into the future.

1.3 Strategic objectives

The Work Program and Corporate Plan 2021–22 outlines activities associated with the following strategic objectives:

Perform IHPA pricing functions

IHPA's primary function is to produce the NEP Determination and the national efficient cost (NEC) Determination each year. The Pricing Framework for Australian Public Hospital Services (the Pricing Framework) 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 NEP and NEC for public hospital services in the next financial year.

Refine and develop hospital activity classification systems

Activity based funding (ABF) 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, mental health care and teaching and training. 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.

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 ABF. 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 NEP. 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.

Develop data requirements and collect hospital data

Timely, accurate and reliable public hospital data is vital to both the development of classifications for hospital services, and to determining the NEP of those services. IHPA has developed a rolling Three Year Data Plan to communicate to the Commonwealth 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.

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.

Conduct independent and transparent decision-making and engage with stakeholders

IHPA works in partnership with the Commonwealth 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.

1.4 Review

IHPA Work Program and Corporate Plan is revised and published each financial year.

At the end of each financial year, IHPA evaluates its performance against the Work Program and Corporate Plan, the results of which are included within the IHPA Annual Report. All IHPA Annual Reports are publicly available on IHPA's website.

2. Key activities

Each strategic objective has key activities which are developed each year. The key activities are detailed below.

Strategic Objective One: Perform Pricing Functions

(a) Development of the Pricing Framework for Australian Public Hospital Services 2022–23

DELIVERABLES	TIMEFRAME
Completion of public submission process for the *Pricing Framework for Australian Public Hospital Services 2022–23*.	July 2021
Provision of the draft *Pricing Framework for Australian Public Hospital Services 2022–23* to health ministers for a 45-day comment period.	September 2021
Publication of the final *Pricing Framework for Australian Public Hospital Services 2022–23* on the IHPA website.	December 2021

IHPA will develop the *Pricing Framework for Australian Public Hospital Services 2022–23* (the Pricing Framework), outlining the principles, scope and methodology to be adopted by IHPA in the setting of the national efficient price (NEP) and national efficient cost (NEC) for public hospital services in 2022–23.

Development of the Pricing Framework includes three major phases: a public consultation period, review of the draft Pricing Framework by health ministers and publication of the final Pricing Framework.

As part of this process, IHPA will also review the costing arrangements for all aspects of organ donation, retrieval and transplantation, following a review of the implementation of the national reform agenda on organ and tissue donation and transplantation.

(b) Determination of in-scope public hospital services for the purposes of Commonwealth funding under the Addendum

DELIVERABLES	TIMEFRAME
Finalise decisions on the *General List of In-Scope Public Hospital Services* for additional or altered in-scope services for 2022−23.	December 2021

IHPA has developed the *General List of In-Scope Public Hospital Services Eligibility Policy* that outlines the process by which jurisdictions can make submissions to IHPA for public hospital services to be determined as in-scope to receive Commonwealth funding.

Full details of the public hospital services determined to be in-scope for Commonwealth funding are provided in the NEP Determination. In 2021–22, IHPA will assess jurisdictions' submissions for additional or altered in-scope services for the NEP Determination 2022–23.

(c) NEP and NEC Determinations 2022–23

DELIVERABLES	TIMEFRAME
Finalise decisions on the legitimate and unavoidable cost variations to assess changes or adjustments to the *National Efficient Price Determination 2022−23*.	December 2021
Provide the draft *National Efficient Price and National Efficient Cost Determinations 2022–23* to health ministers for a 45-day comment period.	December 2021
Publish the *National Efficient Price and National Efficient Cost Determinations 2022–23* on the IHPA website.	March 2022

IHPA's primary function is to produce the NEP and the NEC each year

The NEP represents the price that will form the basis for Commonwealth payments to Local Hospital Networks (LHNs) for each episode of care under the activity based funding (ABF) system. In accordance with the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), IHPA will consider the actual cost of delivery of public hospital services in as wide a range of hospitals as practicable. It will also take into account any legitimate and unavoidable variations in costs due to hospital characteristics (for example, size, type and location) and patient complexity (for example, Indigenous status, location of residence and demographic profile). Health ministers will be requested to identify any unavoidable variations in costs and other factors in their jurisdiction that should be considered by IHPA.

Block funded services

Generally, public hospitals or public hospital services will be eligible for block grant funding if there is either no acceptable classification system available, or activity and cost data collections are not in place in jurisdictions to allow for the pricing and funding of these services on an activity basis. Block funded amounts are included in the NEC Determination each year.

Clauses A49–A55 of the Addendum require that IHPA develop Block Funding Criteria in consultation with states and territories, and that states and territories provide advice to IHPA on how their services meet these criteria. On the basis of this advice, IHPA determines which hospital services and functions are eligible for block funding. The Administrator of the National Health Funding Pool then calculates the Commonwealth contribution.

Coronavirus Disease 2019

Coronavirus Disease 2019 (COVID-19) has resulted in significant and potentially long lasting changes to models of care and service delivery in Australian public hospitals. It is important that these changes are adequately accounted for in the national pricing model as quickly as possible.

IHPA will continue to work with jurisdictions to understand the impact of COVID-19 on service delivery, activity levels and models of care. Any changes to the national pricing model for future NEP iterations will require accurate cost and activity data.

(d) NEP and NEC model refinement

DELIVERABLES	TIMEFRAME
Continue to assess the recommendations provided in the Fundamental Review.	Ongoing

In 2019–20, IHPA initiated a fundamental review of the national pricing model (the Fundamental Review) to ensure the assumptions and methodology underpinning the NEP remain robust and relevant. IHPA continues to work with jurisdictions to consider technical improvements to the pricing model, including the implementation of recommendations from the Fundamental Review.

IHPA will consult with stakeholders when assessing the implementation of recommendations from the Fundamental Review via IHPA's working group structure, and the Jurisdictional and Technical Advisory Committees.

(e) Pricing and funding safety and quality in the delivery of public hospital services

DELIVERABLES	TIMEFRAME
Implementation of a risk adjusted pricing approach to reduce the rates of avoidable hospital readmissions in public hospitals.	July 2021
Development of a framework to evaluate the safety and quality reforms.	April 2021
Investigation and provision of advice on options to reduce preventable hospitalisations.	April 2021
Development of a software tool to track avoidable hospital readmissions.	April 2021
Inclusion of avoidable hospital readmissions rates in the National Benchmarking Portal	December 2021

In May 2020, all Australian governments signed the Addendum, which amends the National Health Reform Agreement for the period from 1 July 2020 to 30 June 2025 and further defines IHPA's role in the incorporation of safety and quality into hospital pricing and funding. Under the Addendum, IHPA is required to continue approaches for sentinel events and hospital acquired complications (HACs) and develop a pricing and funding approach for avoidable hospital readmissions, for implementation from 1 July 2021. The Addendum also requires IHPA to provide advice regarding the evaluation of the existing safety and quality reforms and investigation of new reforms, including options for reducing preventable hospitalisations.

Sentinel events

Sentinel events are preventable adverse events that result in death or serious harm to patients, where serious harm is defined to include requiring life-saving surgical or medical intervention, shortened life expectancy, permanent or long-term physical harm or permanent or long-term loss of function.

The Australian Commission on Safety and Quality in Health Care (the Commission) is responsible for managing the Australian Sentinel Events List, which was initially endorsed by health ministers in 2002.

The Commission undertook a review of the Australian Sentinel Events List in 2017 and the updated list was endorsed by Australian health ministers in December 2018. Version 2.0 of the Australian Sentinel Events List is available on the Commission's website.

Hospital acquired complications

HACs are complications that occur during a hospital stay and where clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The Commission is responsible for the ongoing curation of the HAC list to ensure it remains clinically relevant.

Following a review of all complication groups over 2018–19, the Commission released Version 3.0 of the HACs list in January 2020, which includes updates to falls resulting in fracture or intracranial injury, healthcare-associated infection, surgical complications requiring unplanned return to theatre, venous thromboembolism, gastrointestinal bleeding, incontinence and endocrine complications.

The HAC list is published on the Commission's website.

Avoidable hospital readmissions

An avoidable hospital readmission occurs when a patient who has been discharged from hospital (defined as the index admission) is admitted again within a certain time interval and the readmission is clinically related to the index admission and had the potential to be avoided through improved clinical management or appropriate discharge planning in the index admission.

Under the Addendum, IHPA is required to develop a pricing approach for avoidable hospital readmissions, for implementation from 1 July 2021, following approval from the Council of Australian Governments Health Council (CHC). This is part of the collaborative work with the Commission to incorporate safety and quality measures into funding and pricing for Australian public hospitals to improve patient health outcomes.

On 1 July 2019, IHPA commenced a 24-month shadow period for the three funding options outlined in the Pricing Framework for Australian Public Hospital Services 2019–20. Under the proposed pricing approach, a risk-adjusted National Weighted Activity Unit (NWAU) adjustment is applied to the index episode, based on the total NWAU of the associated readmission. A risk adjustment model has been derived for each readmission condition, which assigns the risk of being readmitted for each episode of care, based on the most clinically relevant and statistically significant risk factors.

This pricing approach was selected based on its similarity to the hospital acquired complications funding adjustment, ease of application and less disproportionate impact across jurisdictions, particularly smaller states and territories with fewer LHNs. The funding adjustment will apply where there is a readmission to any hospital within the same jurisdiction.

Pending CHC approval, IHPA will implement the avoidable hospital readmissions funding adjustment for the NEP Determination 2021–22 and include avoidable hospital readmission rates in the National Benchmarking Portal (NBP).

The list of avoidable hospital readmission conditions and specifications is available on the Commission's website.

IHPA has engaged a contractor to develop commercial grouping software to determine whether a readmission is clinically related to a prior admission. This will allow IHPA to undertake broader investigation of avoidable readmission conditions simultaneously with the current list of avoidable hospital readmissions developed by the Commission.

Further safety and quality reforms

Under the Addendum, IHPA is required to develop a framework to evaluate the safety and quality reforms related to sentinel events, hospital acquired complications and avoidable hospital readmissions, with advice to be provided to CHC by April 2021. IHPA will develop a framework to provide guidance for the evaluation of both existing and future safety and quality reforms against the principles outlined in the Addendum.

IHPA, in conjunction with the Commission, will also provide advice to CHC by April 2021 on the further development of safety and quality reforms, in particular investigating ways to reduce preventable hospitalisations.

(f) Forecast of the NEP for future years

DELIVERABLES	TIMEFRAME
Provide confidential NEP forecast for future years to jurisdictions.	December 2021

Clause B24(h) of the Addendum requires IHPA to develop projections of the NEP for a four-year period. These will be updated annually and confidential reports on these projections will be provided to the Commonwealth, states and territories.

(g) NEC Supplementary Determination

DELIVERABLES	TIMEFRAME
Publish the *Supplementary National Efficient Cost Determination 2021–22*.	December 2021

As the release of the NEP and NEC Determinations in March each year does not align with all state and territory budget cycles, IHPA issues a Supplementary NEC in December which provides an opportunity for states and territories to update their block funded amounts after the finalisation of government budgets.

(h) Price harmonisation across care settings

DELIVERABLES	TIMEFRAME
Investigate opportunities to harmonise prices across similar same-day services.	Ongoing

Included under the Pricing Guidelines are 'System Design Guidelines' that inform options for the design of ABF and block grant funding arrangements, including an objective for 'price harmonisation' whereby pricing should facilitate best-practice provision of appropriate site of care.

IHPA 'harmonises' (i.e. equalises) a limited number of price weights across the admitted acute and non-admitted settings, for example those for gastrointestinal endoscopes, to ensure that similar services are priced consistently across settings. Harmonisation ensures that there is no financial incentive for hospitals to admit patients previously treated on a non-admitted basis due to a higher price for the same service. IHPA seeks advice from its Clinical Advisory Committee when considering whether classes across settings of care are providing a similar type and level of care.

In 2021–22, IHPA will continue to expand price harmonisation for potentially similar same-day services.

Strategic Objective Two: Refine and develop hospital activity classification systems

(a) Acute care classifications

DELIVERABLES	TIMEFRAME
Finalise the refinement of ICD-10-AM/ACHI/ACS Twelfth Edition.	July 2022
Finalise the development of AR-DRG Version 11.0.	July 2022

The classifications for admitted acute care are the *Australian Refined Diagnosis Related Groups (AR-DRG)* and the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI), Australian Coding Standards (ACS)*; collectively referred to as ICD-10-AM/ACHI/ACS.

In 2021–22, IHPA will continue to work on the refinement of the ICD-10-AM/ACHI/ACS Twelfth Edition and AR-DRG Version 11.0.

In 2019, IHPA undertook a review of the AR-DRG and ICD-10-AM/ACHI/ACS classification development cycle and processes. The Final Report of the *Consultation and Review of the AR-DRG and ICD-10-AM/ACHIACS Classification Systems* is published on IHPA's website and outlines the findings and key opportunities to enhance the processes in developing and implementing the AR-DRG and ICD-10-AM/ACHI/ACS classifications. These opportunities are being refined and implemented in the current development cycle, including:

- extending the development cycle timing from two to three years
- embedding principles to focus the development approach
- streamlining clinical and technical input to the classifications
- enhancing education materials and other support for implementation.

(b) Australian Mental Health Care Classification

DELIVERABLES	TIMEFRAME
Refine the mental health phase of care as part of the AMHCC development.	Ongoing
Continue to shadow price admitted mental health care services using the AMHCC Version 1.0 for the *National Efficient Price Determination 2021–22*.	March 2021
Shadow price community mental health care services using the AMHCC Version 1.0 for the *National Efficient Price Determination 2021–22*.	March 2021

The Australian Mental Health Care Classification (AMHCC) Version 1.0 was approved by the Pricing Authority in February 2016 and implemented for data collection from 1 July 2016.

IHPA undertook an inter-rater reliability study in 2016 to test the rate of agreement amongst clinicians in assigning the mental health phase of care (MHPoC) to similar consumers. The findings confirmed the need for further refinement of the MHPoC concept to improve clinical application. As a result, IHPA commenced the Mental Health Phase of Care Clinical Refinement Project in 2017, which proposed two refined MHPoC options and recommended further testing to ensure improved reliability prior to implementation.

In 2020, IHPA initiated the Mental Health Phase of Care Clinical Refinement Testing Project, to test the rate of agreement amongst clinicians in assigning the refined MHPoC options and directly compare findings to the 2016 inter-rater reliability study.

The findings from the Mental Health Phase of Care Clinical Refinement Testing Project will inform a final decision on the refinement of the MHPoC, as well as the development and implementation of AMHCC Version 2.0.

(c) Australian National Subacute and Non-Acute Patient Classification

DELIVERABLES	TIMEFRAME
Consult on the draft AN-SNAP Classification Version 5.0.	November 2021

The development of the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification Version 4.0 was completed in late 2014.

IHPA continues to work with the Subacute Care Working Group, Clinical Advisory Committee and other advisory groups to develop the next version of the AN-SNAP classification. The AN-SNAP Version 4.0 Final Report highlighted that a key limitation to developing prior versions was the lack of data to inform the development of options for making major structural changes to the classification. Considerable progress has since been made by states and territories in the collection of subacute activity and cost data which will support improvements for AN-SNAP Version 5.0.

As part of the development of AN-SNAP Version 5.0, IHPA continues to investigate potential new variables and the cost impact of complications and comorbidities on all of the care types.

(d) Tier 2 Non-Admitted Services Classification

DELIVERABLES	TIMEFRAME
Continue to maintain the Tier 2 Non-Admitted Services Classification while undertaking development work for the ANACC.	Ongoing

The Tier 2 Non-Admitted Services Classification system categorises a public hospital's non-admitted services into classes which are generally based on the nature of the service provided an/d the type of clinician providing the service.

IHPA is developing a new Australian Non-Admitted Care Classification (ANACC). The data and knowledge gained through the development of the ANACC will inform IHPA's work to maintain the Tier 2 Non-Admitted Services Classification while development takes place.

(e) Australian Non-Admitted Care Classification

DELIVERABLES	TIMEFRAME
Complete the non-admitted care costing study, including activity and cost data for the ANACC.	Ongoing

The ANACC will better describe patient characteristics and the complexity of care in order to more accurately reflect the costs of non-admitted services. The new classification will account for changes in how care is delivered as services transition to the non-admitted setting, as new electronic medical records allow for more detailed data capture and testing of new funding models which span multiple settings.

In 2019, a national costing study was initiated to collect non-admitted (including non-admitted subacute) activity and cost data and test the shortlist of presenting conditions, interventions and patient-centred variables. The outcomes of the costing study will underpin the development of a final hierarchy and end classes for the new classification and the associated non-admitted data sets. In July 2020, the national costing study was suspended due to the COVID-19 pandemic. IHPA will review the strategy for non-admitted care as a result in the delay to the development of the ANACC.

(f) Australian Emergency Care Classification

DELIVERABLES	TIMEFRAME
Price emergency department activity using the AECC Version 1.0 for the *National Efficient Price Determination 2021–22*.	March 2021
Refine the AECC Version 1.0.	Ongoing

In late 2018, IHPA finalised Version 1.0 of the Australian Emergency Care Classification (AECC) in consultation with the Emergency Care Advisory Working Group, Clinical Advisory Committee and other advisory groups. The AECC was approved by the Pricing Authority in July 2019.

IHPA will continue to support jurisdictions to improve data collection and reporting of existing variables along with future refinement of the classification that potentially considers the addition of new variables for collection in the Non-admitted patient emergency department care National Minimum Data Set.

(g) Australian Teaching and Training Classification

DELIVERABLES	TIMEFRAME
Continue to work with jurisdictions to implement ATTC.	June 2022

The Addendum requires IHPA to provide advice on the feasibility of transitioning funding for teaching, training and research to ABF. The Australian Teaching and Training Classification (ATTC) Version 1.0 was released on 1 July 2018.

The ATTC will improve reporting of hospital-based teaching and training activity and in the future improve the transparency of funding. States and territories broadly support ATTC but note there are challenges related to its implementation, such as the availability of activity and cost data.

In 2021–22, IHPA will continue to work with states and territories to increase awareness of the ATTC and improve the reporting of activity and cost data to support implementation.

Research is not incorporated into the ATTC and no further work is proposed for a research classification at this stage.

(h) Sales of the AR-DRG system

DELIVERABLES	TIMEFRAME
Management of the international sales of the AR-DRG system.	Ongoing

IHPA assumed responsibility for managing the development and international sales of the AR-DRG patient classification system as the custodian of the Commonwealth's Intellectual Property in the AR-DRGs in 2012–13.

In 2021–22, IHPA will continue to manage the international sales of the AR-DRG system.

(i) Incorporating new technology in patient classification systems

DELIVERABLES	TIMEFRAME
Update the *Impact of New Health Technology Framework* to review the process for assessing the impact of new health technologies on patient classification systems and include process for incorporating new high cost, highly specialised treatments	June 2021
Finalise the review of new health technologies based on reports received from government agencies and advisory bodies.	June 2022

The *Impact of New Health Technology Framework* outlines the process by which IHPA will monitor and review the impact of new health technologies on the existing classifications in order to accurately account for them in the pricing of public hospital services.

In 2020–21, IHPA commenced a review of the process for assessing the impact of new health technologies on patient classification systems, following the outcomes of the end-to-end review of the AR-DRG classification system development process. The end-to-end review included considering how high acuity, high cost health technology could be incorporated into the classification system in a more timely fashion.

An initial review of potential mechanisms to address the lack of agility of the admitted classifications in keeping pace with new technologies identified an option to develop a set of codes in ACHI to be used as placeholders for new health technology. This enables collection of intervention data for new technologies without having to wait for a new edition of ACHI to be released. IHPA will work with jurisdictions to develop an approach to determine when a new technology would qualify for a placeholder code and, subsequently, when a placeholder code would be formally integrated into ACHI.

Clauses C11 and C12 of the Addendum contain specific arrangements for new high cost, highly specialised therapies recommended for delivery in public hospitals by the Medical Services Advisory Committee. IHPA will work with jurisdictions to develop an approach for funding new high cost, highly specialised therapies. As part of this process, IHPA will review the *Impact of New Health Technology Framework* to outline the process for incorporating new high cost, highly specialised treatments into the classification systems and the pricing model.

In 2021–22, IHPA will continue to monitor and review the impact of new health technologies on the existing classifications based on reports from government agencies and advisory bodies, and will determine whether and how the classification systems should be adjusted in response.

Strategic Objective Three: Refine and improve hospital costing

(a) Australian Hospital Patient Costing Standards

DELIVERABLES	TIMEFRAME
Review and update AHPCS Version 4.0 in consultation with the NHCDC Advisory Committee and jurisdictions	June 2021

The Australian Hospital Patient Costing Standards (AHPCS) are published for those conducting national costing activities, to promote consistency in data submission. The AHPCS provide the framework for regulators, funders, providers and researchers for the cost data collection.

In 2018–19, IHPA published Version 4.0 of the AHPCS. This version was restructured to incorporate a set of overarching principles to guide the costing process and to include business rules which provide detailed guidance from the costing practitioners' perspective on how a costing standard can be translated into action, while taking into account practical and operational constraints within organisations. It is intended that the changes to the AHPCS will result in greater consistency in activity based costing for future rounds of the National Hospital Cost Data Collection (NHCDC).

IHPA will work with its NHCDC Advisory Committee and jurisdictions to review and update the AHPCS Version 4.0, as required.

(b) Collection of NHCDC for public and private hospitals

DELIVERABLES	TIMEFRAME
Release Round 24 NHCDC public sector report.	December 2021
Release Round 24 NHCDC cost weight tables for private hospitals.	December 2021

In 2021–22, IHPA will continue to collect and analyse the NHCDC and will continue to develop a stronger compliance framework in conjunction with the NHCDC Advisory Committee.

Since IHPA's implementation of the Secure Data Management System (SDMS), the submission process for the NHCDC has been greatly improved, with greater flexibility of file upload specifications, faster validation and reporting, and enhanced capabilities for jurisdictions to track and manage their submission process.

(c) NHCDC Independent Financial Review

DELIVERABLES	TIMEFRAME
Release the NHCDC Round 24 Independent Financial Review.	December 2021

An annual component of the NHCDC cycle is the Independent Financial Review. IHPA commissions an independent body to review public sector data provided by jurisdictions, with a specific focus on hospitals' financial reconciliations and consistent application of the AHPCS.

The Independent Financial Review provides transparency around the data submission with a review and reconciliation of the data flow from hospital submission through to finalisation in the national dataset.

(d) Costing private patients in public hospitals

DELIVERABLES	TIMEFRAME
IHPA will continue to work towards phasing out the private patient correction factor for all jurisdictions for NEP22.	November 2021

The collection of private patient medical expenses has been problematic in the NHCDC. For example, there is a common practice in some jurisdictions of using Special Purpose Funds to collect associated revenue (for example, Medicare Benefits Schedule) and reimburse medical practitioners.

The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the NHCDC. Submissions in response to previous consultation papers on the Pricing Framework have supported phasing out the correction factor when feasible.

It is anticipated that the implementation of the AHPCS Version 4.0 will address this issue, meaning that the private patient correction factor is no longer required. AHPCS Version 4.0 includes a Business Rule relating to the treatment of medical and other expenses found in Special Purpose Funds which manage Rights of Private Practice arrangements. It is intended that the business rule will support states and territories in accounting for all expenses contributing toward hospital activities, regardless of their funding source.

Following the implementation of the AHPCS Version 4.0 and changes to reporting private patient costs in the NHCDC, IHPA intends to phase out the private patient correction factor for the Northern Territory for NEP21. IHPA will continue to work with the remaining jurisdictions to phase out the private patient correction factor for NEP22.

Strategic Objective Four: Determine data requirements and collect data

(a) Revision of the Three Year Data Plan

DELIVERABLES	TIMEFRAME
Publish the Three Year Data Plan 2022–23 to 2024–25.	June 2022

IHPA's rolling *Three Year Data Plan* communicates the data requirements, data standards and timelines that IHPA will use to collect data over the coming three years from jurisdictions.

IHPA supports the concept of 'single provision, multiple use' of information to maximise data provision efficiency, and continues to align its rolling *Three Year Data Plan* with the National Health Funding Body's data plan to support this aim.

In 2021–22, IHPA will update the rolling *Three Year Data Plan* and provide it to the Health Services Principal Committee (HSPC), the Australian Health Ministers Advisory Council and the eventual replacement of the CHC for consideration.

(b) Data specification development and revision

DELIVERABLES	TIMEFRAME
Complete the annual review of ABF National Best Endeavours Data Sets and National Minimum Data Sets.	December 2021

IHPA completes an annual review of the National Best Endeavours Data Sets and National Minimum Data Sets required for ABF to incorporate data elements required for ABF with existing data collections.

IHPA will continue to work closely with the HSPC and other data committees to incorporate new elements as required for classification development, as well as consolidate existing data collections.

(c) Individual Healthcare Identifier

DELIVERABLES	TIMEFRAME
Develop the process for the collection of the IHI as part of national data sets.	June 2022

The Individual Healthcare Identifier (IHI) is an existing person identifier that could be included in national data sets. A robust person identifier would allow IHPA to accurately identify service delivery to patients across settings of care, financial years and hospitals.

Linked patient data provides broad benefits to the health system, allowing hospitals to review care pathways and develop value-based healthcare proposals. A patient identifier is also essential to progress work on avoidable hospital readmissions to enable the linkage of patients across different hospitals or service settings.

IHPA will continue to work with jurisdictions and national data committees to progress the inclusion of the IHI in the national data collections used for ABF purposes and ensure that there are appropriate protections and safeguards for consumers.

(d) Improvements to data submission, loading and validation processes

DELIVERABLES	TIMEFRAME
Further develop the SDMS functionality.	Ongoing

In 2017, IHPA implemented a new SDMS. This dynamic tool built specifically for IHPA includes a new data submission portal, data validation process, data storage and data analytics platform. This new system has introduced greater flexibility of file upload specifications, faster validation and reporting, and enhanced capabilities for jurisdictions to track and manage their submission process.

IHPA will implement a refresh to the SDMS from late 2020. This activity will consolidate improvements made since 2017, and update the system to operate using modern architectures and practices. Further improvements are expected to the robustness and speed of data submission, loading and validation on the SDMS.

IHPA will continue working with key stakeholders to enhance the data submission portals in SDMS.

(e) Collection of ABF activity data for public hospitals

DELIVERABLES	TIMEFRAME
Collect jurisdictional submissions for March quarter 2021 ABF activity data.	June 2021
Collect jurisdictional submissions for June quarter 2021 ABF activity data.	September 2021
Collect jurisdictional submissions for September quarter 2021 ABF activity data.	December 2021
Collect jurisdictional submissions for December quarter 2021 ABF activity data.	March 2022

During 2021–22, IHPA will continue its collection of ABF activity data on a quarterly basis, while teaching, training and research and hospital cost data provided through the NHCDC is reported on an annual basis.

In response to COVID-19, IHPA commenced a new data submission to identify activity to be funded through the National Partnership Agreement for COVID-19. The supplementary COVID-19 data will be submitted to IHPA along with quarterly ABF activity data submission.

Based on quarterly data collections, IHPA will undertake activity analysis which will be used to monitor the impact of the NEP pricing model on the hospital system.

(f) Data compliance

DELIVERABLES	TIMEFRAME
Publish data compliance report for March quarter 2021.	September 2021
Publish data compliance report for June quarter 2021.	December 2021
Publish data compliance report for September quarter 2021.	March 2022
Publish data compliance report for December quarter 2021.	June 2022

IHPA publishes details of jurisdictional compliance with data requirements as required by clause B81of the Addendum. Both ABF hospital activity and cost data collections are assessed in accordance with IHPA's *Data Compliance Policy*. All data compliance reports are publicly available on IHPA's website.

As outlined in the Addendum, from 1 July 2017, jurisdictions will be required to provide IHPA with a 'Statement of Assurance' on the completeness and accuracy of approved data submissions. This is outlined in more detail in the IHPA *Three Year Data Plan*.

(g) Promoting access to public hospital data

DELIVERABLES	TIMEFRAME
Continue to expand access to the NBP.	Ongoing

The NBP is a secure web-based application that allows users to compare cost and activity from hospitals around the country. It gives users the ability to compare differences in activity, cost and efficiency at similar hospitals using the NWAU, as well as comparing rates of HACs.

In 2018, IHPA added HAC risk adjustment measures to the NBP in support of pricing for the safety and quality of hospital service delivery and in 2021–22 will add hospital readmission rates. IHPA will continue to work with jurisdictions to consider how the NBP can be further improved through the inclusion of safety and quality indicators to better support system and hospital managers for benchmarking purposes.

IHPA is working to ensure that access to the NBP is available to all Local Hospital Networks and public hospitals, and will continue exploring mechanisms to allow this without compromising the security of the system. IHPA is also working to provide public access to the NBP.

Strategic Objective Five: Resolve disputes on cost-shifting and cross-border issues

(a) Review of the Cost-Shifting and Cross-Border Dispute Resolution Framework

DELIVERABLES	TIMEFRAME
Conduct annual review of the *Cost-Shifting and Cross-Border Dispute Resolution Framework*.	June 2022

As outlined in Part 4.3 of the *National Health Reform Act 2011*, IHPA has a role to investigate and make recommendations concerning cross-border disputes and to make assessments of cost-shifting disputes.

IHPA developed the Cost-Shifting and Cross-Border Dispute Resolution Framework to guide timely, equitable and transparent processes to investigate both cross-border and cost-shifting disputes.

The framework is reviewed annually in consultation with all jurisdictions to ensure it remains current to sufficiently support IHPA's cross-border and cost-shifting dispute resolution role. This annual review will consider the manageability of the framework for all parties involved within the bounds of the prescribed legislative requirements.

Strategic Objective Six: Conduct independent and transparent decision-making and engage with stakeholders

(a) Monitor and evaluate the introduction of ABF

DELIVERABLES	TIMEFRAME
Provide quarterly ABF activity data reports to the Pricing Authority and Jurisdictional Advisory Committee.	Ongoing

In 2021–22, IHPA will continue to monitor changes in the mix, distribution and location of public hospital services each quarter, and conduct an annual analysis of the impacts of ABF implementation on the delivery of public hospital services through the ABF Monitoring Framework.

Consistent with clause A31 of the Addendum, should IHPA identify anomalies in service volumes or other data which suggest that services have been transferred from the community to public hospitals for the dominant purpose of making that service eligible for Commonwealth funding, IHPA will in the first instance consult with the jurisdictions in question to ascertain what underlying factors may be driving movements in service volumes.

(b) Evidence-based ABF related research

DELIVERABLES	TIMEFRAME
Publish evidence-based ABF related research and analysis.	Ongoing
Development of a funding methodology for innovative funding models.	April 2021

In accordance with clause B31 of the Addendum, IHPA may undertake research. Evidence-based research plays a very significant role in the ongoing advancement of activity based funding (ABF) in Australia. This is particularly the case in improving the understanding of the relationship between public hospital activity and costs in all care settings.

As required, IHPA will conduct ABF related research that furthers the understanding and implementation of ABF, particularly including classifications, coding standards and pricing methodologies. As a result, IHPA will be in a better position to determine an national efficient price that accurately reflects the costs experienced by Australian public hospitals.

Publication of ABF related research

IHPA considers that broadening access to its data and greater publication of analysis using the data would benefit work to develop and evaluate health policy and programs by researchers, clinical groups and peak bodies and would serve the interests of transparency.

IHPA will continue to work with stakeholders to improve access to hospital data, including developing appropriate safeguards and identifying opportunities that all parties are agreeable to in the release of data and/or publications to third parties.

Alternative funding models

The Pricing Guidelines and the Addendum include provisions for IHPA to consider the impact on its work of evidence-based, effective new technologies and innovations in models of healthcare. IHPA maintains a watching brief on emerging trends in healthcare to ensure that current ABF framework can accommodate new and alternate approaches to public hospital funding and service delivery.

While ABF has increased the transparency of hospital services and costs, it has the potential to incentivise more activity or to admit patients instead of focusing on hospital avoidance and patient outcomes. Consequently, there is a growing discussion in Australia and internationally about the need to increase focus on delivering value-based healthcare with a focus on patient outcomes and experience.

Following on from the Global Horizon Scan in March 2019, IHPA developed a roadmap for exploring innovative funding models such as capitation and bundled payments.

Schedule C of the Addendum supported the approach and provided key references to paying for value and outcomes through supporting innovative models of care and trialling new funding arrangements enabling IHPA to build on its strategy in 2021–22.

In 2021–22, IHPA will continue exploring innovative funding models, including completing the evaluation of the Victorian HealthLinks Program with a view to adapting it to a national capitation model that would be appropriate for hospital avoidance programs. IHPA will also develop a framework to guide work to investigate the feasibility of innovative funding models at a national level. The framework will provide clear guidance to Australian governments in determining its approach to trialling different funding models and IHPA's role in facilitating this work.

(c) Support ABF education at a national level

DELIVERABLES	TIMEFRAME
Implementation of strategies, tools and working papers to ensure that IHPA is providing information that will inform its stakeholders.	Ongoing
Activity Based Funding conference 2021.	May 2021

IHPA recognises that the responsibility for ABF education rests with states and territories as the managers of the public hospital system.

In 2021–22, IHPA will continue to implement strategies to ensure that it is providing information that will inform its stakeholders and support ABF education activities, through the provision of education tools and resources.

IHPA holds an annual conference aimed at providing high-quality education in ABF and the underlying classification, costing and data collection systems to key health sector personnel. The conference includes major plenary sessions, concurrent smaller presentations, workshops/training, and networking activities. It provides delegates an opportunity to hear from international peers in the healthcare industry about how their systems function.

Due to COVID-19, IHPA made a decision to postpone its next in-person ABF conference as originally planned in Brisbane in May 2021 to 2022. The COVID-19 restrictions have prompted IHPA to look at alternative ways to deliver its educational responsibilities as outlined in its Work Program 2020–21.

Delivering educational programs on ABF will ensure that there are continuing opportunities for engagement and professional development, and will present an opportunity for diverse roles, including early-career professionals, who are cost prohibited to attend the conference in person.

3. Operating context

The operating context describes IHPA's environment, capability, cooperation and collaboration, and enterprise risk.

3.1 Environment

IHPA operations are influenced by advances in technology that enable digitisation, automation and visualisation. International and Australian developments in best practice and research continuously inform policy and practice. As the long term impact of Coronavirus Disease 2019 (COVID-19) is still uncertain, IHPA will consider potential impacts on its operating context when information becomes available.

3.2 Capability

Human resources

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 (for example, in gender, age, cultural and linguistic background, disability, Aboriginal and Torres Strait Islander, and LGBTI+) workforce, and actively promotes an inclusive workplace culture. Training and development are provided on a programmed basis and needs basis to individual staff. Additionally, mid-level and senior management staff undertake leadership training.

IHPA's work program incorporates a substantial amount of technical work that requires significant specialist workforce capability. IHPA's workforce planning strategies will continue to emphasise both core public sector skills and the enhancement of the expert skills IHPA requires to meet its objectives.

IHPA will also continue to strengthen its management and leadership teams by enhancing performance feedback and providing targeted learning and development programs.

The key focus areas for 2021–22 include continuing to:

- develop capability through attendance at internal and external training opportunities
- monitor staff turnover rates and give genuine consideration to feedback provided via the annual Australian Public Service 'State of the Service' report
- support flexible working arrangements and agile work practices.

Infrastructure

IHPA will continue to enhance infrastructure to support the national activity based funding system by:

- developing and refining new and existing hospital activity classifications through specialist input from clinicians, and other stakeholders
- establishing and maintaining national costing standards
- developing and maintaining standards for activity data collections, including the annual publication of the *Three Year Data Plan*
- publishing a quarterly report outlining jurisdictional compliance with the data requirements and data standards as set out in the *Three Year Data Plan*.

ICT

Information technology is essential to IHPA's core business and performance enabling data analysis, digitisation and automation, engagement and a highly mobile workforce. Robust measures are in place to test and upgrade data security.

IHPA will continue to utilise secure cloud capabilities to deliver its Secure Data Management System (SDMS) and other secure information-based systems. The SDMS allows jurisdictions to securely submit data to IHPA, and for IHPA to securely retain this information while intensive analysis is undertaken. Into 2021-22, IHPA will examine options to uplift Information and Communication Technology (ICT) capability, focusing on further maturing the security, functionality, and value delivered.

3.3 Cooperation and collaboration

IHPA works with stakeholders from government agencies, research and education, the community and industry. This is achieved through consultative and advisory committees and working groups with expertise in specialised fields enabling a knowledge pipeline for technical advances and best practice innovation. IHPA committees and working groups are listed in Table 1.

Table 1. List of IHPA committees and working groups

Board	Committees	Working groups	
Pricing Authority	Clinical Advisory Committee Jurisdictional Advisory Committee Stakeholder Advisory Committee Technical Advisory Committee National Hospital Cost Data Collection Advisory Committee	Emergency Care Advisory Working Group Mental Health Working Group Teaching, Training and Research Working Group Subacute Care Working Group	Small Rural Hospitals Working Group Non-admitted Care Advisory Working Group Diagnosis Related Groups Technical Group Classifications Clinical Advisory Group ICD Technical Group

3.4 Enterprise risk

Since the agency's formation in 2011, IHPA 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 including 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.

IHPA's enterprise approach to risk management uses tools that address the strategic and tactical risks of all significant decisions. IHPA has a comprehensive risk management framework and a detailed risk appetite statement, which is regularly reviewed.

Table 2 identifies the following risks and their controls: reputational, data and information governance, information and communication technology, outsourcing and procurement, physical security, compliance, fraud and corruption, financial, people and culture, and delivery of legislative functions.

Strategic risks

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 maintains 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

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.

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 regularly 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.

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 manages 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.

Financial authorisation

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

Audit, Risk and Compliance Committee

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

Table 2. Risk and controls

Risk	Controls
Reputational	
IHPA is not seen as an independent organisation	Priority given to maintaining IHPA's independence. Regularly updating the governance framework. Declaration, recording and monitoring material personal interests at committee meetings, and managed in accordance with IHPA Policies. Public Interest Disclosure Policy in place. Consultation with all state and territory government committees, working groups and legislative consultation process. Public consultation process for Pricing Framework and Corporate Plan. Public reporting of the Strategic Plan and Corporate. Internal and external expert advice and quality assurance in delivering core functions. Transparent evidence-based methodology in decision-making (for example, for the determination of the national efficient price and national efficient cost, dispute resolution). Ensuring that IHPA staff, members of Advisory and Working Committees are aware of IHPA policies and practices through induction and training. Media monitoring and proactive media briefing.
Communication of IHPA's role is not effective	Annual Activity Based Funding Conference. Extensive stakeholder consultation through committees and working groups. Public consultation processes for Pricing Framework, Work Program and other major pieces of work. Consolidated social media engagement presence. Media briefing on significant decisions and bodies of work.

Data and Information Governance Risks	
Data supplied is not accurate	Governance structure and business processes established to check the quality and integrity of incoming and outgoing data, including: • Data standards and specifications are determined and provided to data custodians • Data Quality Management Framework and assurance processes for activity and cost data. • Three Year Data Plan. • Compliance reporting of the data provided by Jurisdictions including a Statement of Assurance from jurisdiction verifying that the data meets IHPA's specifications. Activity reporting quarterly enabling timelier monitoring of any impacts and making it possible to identify and address any anomalies in the data.
Delays in the provision of data	Data compliance process which issues reminders at relevant times. An appropriate escalation process.
A data breach occurs	Systems, policies and procedures are in place to prevent data breaches, including: • SDMS environment fully compliant with the relevant Australian Government's Information Security Manual • IHPA Fraud and Corruption Control Plan • Third Party Usage of IHPA Protected Data Rules, implemented and regularly reviewed • Information Release Policy Data and IT management controls. Annual Data Governance assurance audits conducted by internal auditors and all findings remediated.
Core business records not retained	IHPA uses the Department of Health TRIM based record management system for its core business. IHPA's records are regularly updated, backed up and stored securely. IHPA's SDMS provider independently maintains information in accordance with Australian Government requirements including independent backup to other sites.
Information and Communication Technology	
ICT performance failure or loss of critical ICT systems ICT systems not suited to IHPA's business needs	Health ICT system controls: • Memorandum of Understanding with Health outlines ICT arrangements • Regular meetings with between IHPA and Health shared services • IHPA specific TRIM structure and naming conventions established • Range of TRIM training provided. SDMS controls: • Implementation of comprehensive IT management policies • Compliance with Australian Signals Directorate top four security strategies and the Commonwealth Information Security Manual Compliance • Standard Operating Environments defined for notebooks and the IHPA server • Use of expert external IT security advisor to provide security advice.
Outsourcing and Procurement	
Inadequate procurement process and contract outcomes not achieved	Use of Shared Services expert procurement advisors from the Department of Health. Legal advice on amendments to any standard contract from Executive Officer. External legal advice for complex contracts. Simplified Tactical Risk tool available and utilised. Procurement and contract management policies and templates. Staff training on negotiation skills and communication. Regular review of procurement processes by IHPA's internal auditors and the IHPA Audit, Risk and Compliance Committee. Procurement, contract management policies and templates are regularly updated.
Physical Security	
Physical security of or staff, visitors or contractors/asset security is insufficient	Staff have annual security training. Regular site wide security assessments Pass access or escorted access only. Security checks undertaken All new staff and contractors are provided with security training. IT asset register and general asset register maintained. All assets IHPA assets secured in compliance with IHPA's asset management policy. Offsite assets must be signed out and returned in compliance with IHPA policies. Minimum IT assets held on premises.

Independent Hospital Pricing Authority

Level 6, 1 Oxford Street
Sydney NSW 2000

Phone 02 8215 1100

Email enquiries.ihpa@ihpa.gov.au

Twitter @IHPAnews

ihpa.gov.au