Annual Report

2016–17

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 2017, in accordance with the *National Health Reform Act 2011* and pursuant to section 46 of the *Public Governance, Performance and Accountability Act 2013* (the PGPA Act).

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 as required under other applicable legislation, including the *Work Health and Safety Act 2011*.

As the Accountable Authority for the purposes of the PGPA Act, 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 2017

01

About IHPA

Enabling legislation

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

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.

Functions and purpose

Pursuant to the *National Health Reform Act 2011*, the main functions of IHPA are 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 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 in relation to the efficient costs of public hospital services, and developing and implementing robust systems to support Activity Based Funding for those services. (See 'What is Activity Based Funding?' at p12.)

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.

Pricing and funding for safety and quality

During the financial year 2016–17 IHPA undertook work to develop and evaluate options for introducing safety and quality into pricing and funding models for Australian public hospitals.

On 30 November 2016 IHPA provided advice to the COAG Health Council on options for the integration of safety and quality into public hospital pricing and funding. In this advice, IHPA proposed one approach for sentinel events (such as surgical procedures involving the wrong body part or medication errors leading to death), one approach for hospital acquired complications (HACs), and an initial approach on avoidable readmissions.

In February 2017, the Hon. Greg Hunt MP, the Minister for Health, acting under section 226 of the *National Health Reform Act 2011* directed IHPA to work to implement the three recommendations it had made to the COAG Health Council. These recommendations are reflected in the *Pricing Framework for Australian Public Hospital Services 2017–18*.

Responsible Minister

The Independent Hospital Pricing Authority sits within the Department of Health portfolio. There have been two Ministers responsible for this reporting period.

- The Hon. Sussan Ley MP, Minister for Health and Aged Care, 1 July 2016 – 24 January 2017 (stood aside on 9 January 2017).
- The Hon. Greg Hunt MP, Minister for Health, 24 January 2017 – 30 June 2017.

Ministerial Directions and government policy orders

In 2016–17 IHPA received two Ministerial Directions. It also received a request for a report in accordance with Section 208 of the *National Health Reform Act 2011*.

1. On 29 August 2016 IHPA received a Ministerial Direction from the Hon. Sussan Ley, under section 226 of the *National Health Reform Act 2011*.

   The Direction required the Independent Hospital Pricing Authority (IHPA) to provide advice to the Commonwealth and states and territories on options for developing:

   - a comprehensive and risk-adjusted model to determine how funding and pricing can be used to improve patient outcomes and reduce the amount the Commonwealth pays for sentinel events, and a set of preventable hospital acquired conditions, defined by the Australian Commission on Safety and Quality in Health Care and agreed by the Parties, that occur in public hospitals; and
   - a comprehensive and risk-adjusted strategy and funding model to reduce avoidable readmissions to hospital that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for an agreed set of conditions and the circumstances in which they occur.

   The Direction specified that IHPA provide advice to the COAG Health Council regarding options by 30 November 2016.

On 30 November 2016 IHPA provided advice to the COAG Health Council on options for the integration of safety and quality into public hospital pricing and funding.

2. On 16 February 2017 IHPA received a Ministerial Direction from the Hon. Greg Hunt under section 226(1) of the *National Health Reform Act 2011*.

   The Direction required that IHPA undertake implementation of agreed recommendations of the COAG Health Council on pricing for safety and quality to give effect to:

   - Nil funding for a public hospital episode including a sentinel event which occurs on or after 1 July 2017, applying to all relevant episodes of care (being admitted and other episodes) in hospitals where the services are funded on an activity basis and hospitals where services are block funded.
   - An appropriate reduced funding level for all hospital acquired complications, in accordance with Option 3 of the draft *Pricing Framework for Australian Public Hospital Services 2017–18*, as existing on 30 November 2016, to reflect the additional cost of a hospital admission with a hospital acquired complication, to be applied across all public hospitals.
   - Undertake further public consultation to inform a future pricing and funding approach in relation to avoidable hospital readmissions, based on a set of definitions to be developed by the Australian Commission on Safety and Quality in Health Care.

IHPA incorporated the requirements under this Direction into the final *Pricing Framework for Australian Public Hospitals 2017–18* published on the IHPA website in early March 2017.

IHPA will undertake further consultation as part of its annual consultation process on the draft *Pricing Framework for Australian Public Hospitals 2018–19* due for publication in June 2017 and provide a report back to the COAG Health Council by 30 November 2017.

What is Activity Based Funding?

Activity Based Funding (ABF) means hospitals are paid for the number and complexity of patients they treat. If a hospital treats more patients, it receives more funding. ABF takes into account the fact that some patients are more complicated to treat than others.

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

The building blocks required for an ABF system are:

Classification

Classifications provide the health care sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs in order to provide better management, measurement and funding of high quality and efficient health care services. More information about IHPA's classifications and how they are developed is available at www.ihpa.gov.au/what-we-do/classifications.

Data collection

Each patient episode needs to be counted. This includes inpatient admissions, emergency department presentations and outpatient appointments as well as a range of mental health and rehabilitation services. More information about IHPA's data collection is available at www.ihpa.gov.au/what-we-do/data-collection.

Costing

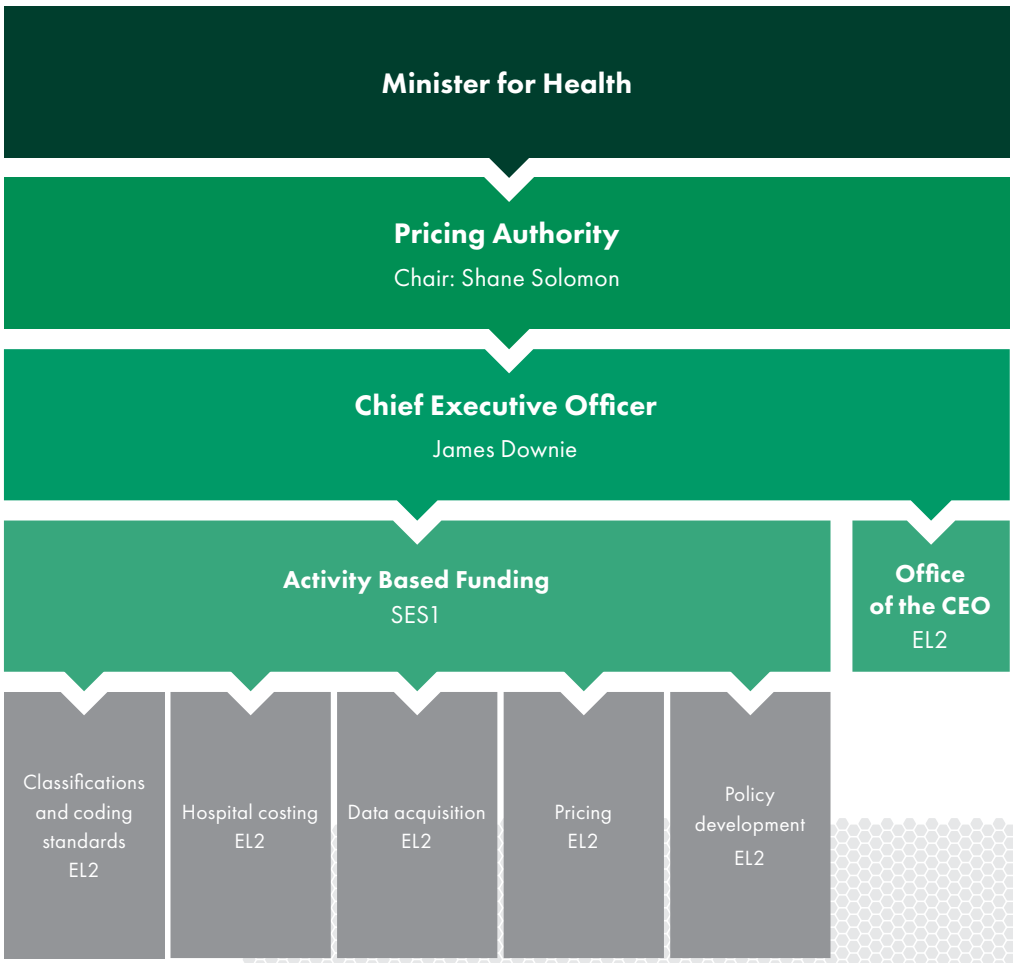
A representative number of patient episodes are costed. This information is used for developing the classification system and for the pricing model. More information about IHPA's costing activities is available at www.ihpa.gov.au/what-we-do/costing.

Pricing

The pricing model determines how much is paid for an average patient. The pricing model needs to adequately recognise factors that increase the cost of care that may not be picked up in the classification system, for example the additional cost of providing health services in remote areas, or to children. More information about IHPA pricing activities is available at www.ihpa.gov.au/what-we-do/pricing.

Organisational structure

Figure 1: IHPA's organisational structure at 30 June 2017



The Pricing Authority is a body corporate consisting of a Chair, Deputy Chair, and up to seven other members. The Chair of the Pricing Authority reports directly to the Minister for Health. For more about the Pricing Authority, see p19.

The Chief Executive Officer is responsible for the day-to-day management of IHPA and its staff. Pursuant to 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 the purposes of this Annual Report.

To achieve its annual Work Program, IHPA works in collaboration with all Commonwealth and state and territory governments, advisory committees, key stakeholders and the public.

IHPA's statutory committees comprise the Clinical Advisory Committee (CAC) and the Jurisdictional Advisory Committee (JAC), established pursuant to Parts 4.10 and 4.11 of the *National Health Reform Act 2011*. (An Annual Report for CAC is included within the IHPA Annual Report at p33.)

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

James Downie was appointed Chief Executive Officer of the Independent Hospital Pricing Authority on 1 September 2016, having acted in the role since June 2015. Prior to this James was the 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.

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.

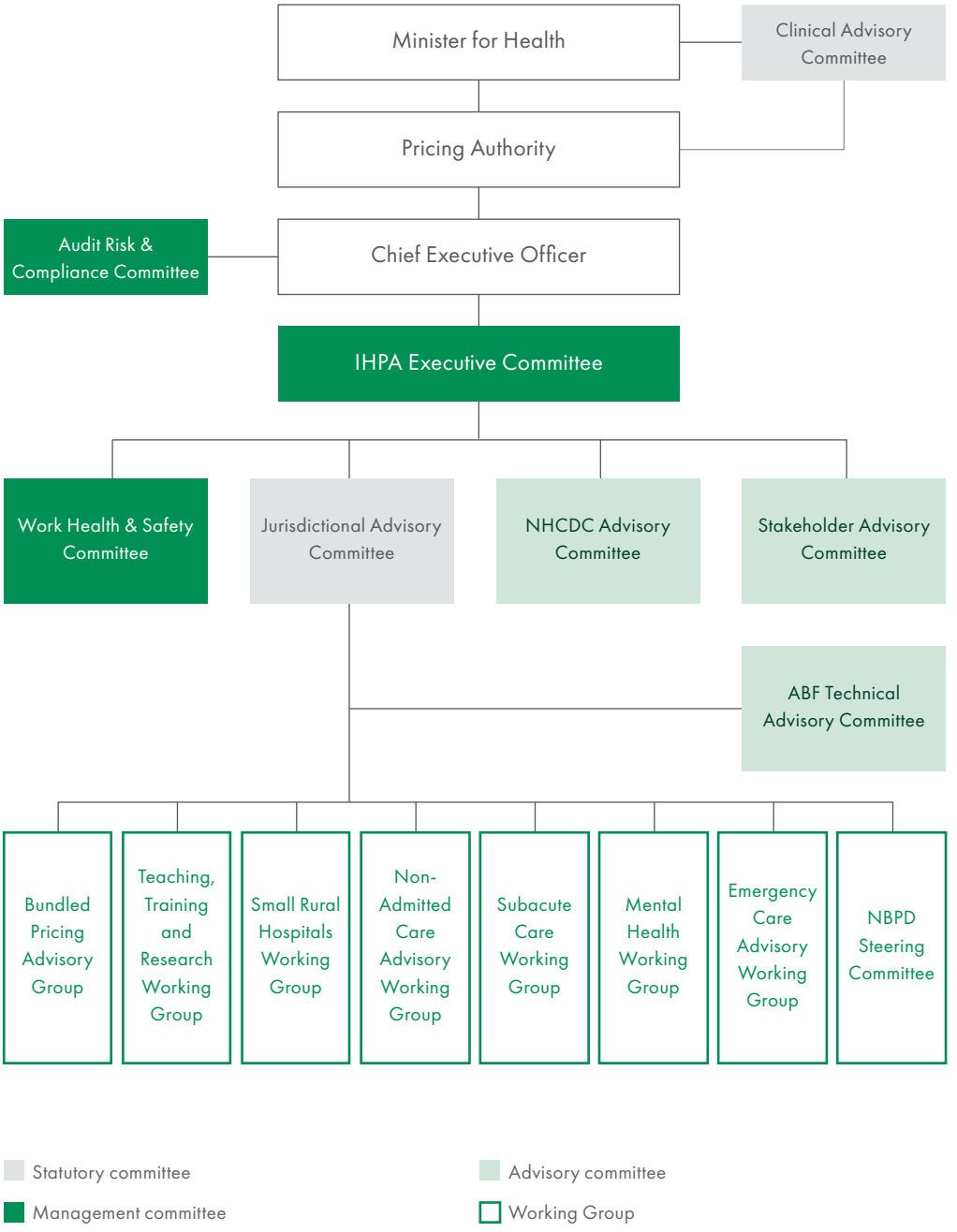
IHPA's statutory committees comprise the Clinical Advisory Committee and the Jurisdictional Advisory Committee.

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*, including:

- Stakeholder Advisory Committee
- Activity Based Funding Technical Advisory Committee
- National Hospital Cost Data Collection Advisory Committee
- Teaching, Training and Research Working Group
- Small Rural Hospitals Working Group
- Non-admitted Care Advisory Working Group
- Subacute Care Working Group
- Mental Health Working Group
- Emergency Care Advisory Working Group
- Bundled Pricing Advisory Group
- National Benchmarking Portal Development Steering Committee
- Audit Risk and Compliance Committee
- Work, Health and Safety Committee

Working groups and committees 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, delegated power, membership and reporting relationship.

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



Clinical Advisory Committee

The Clinical Advisory Committee (CAC) is established under section 177 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, the functions of the Pricing Authority, and matters referred to it by the Pricing Authority.

CAC members are appointed by the Australian Government Minister for Health. At 30 June 2017, the CAC consisted of 26 members.

The CAC is required to report annually. The CAC Annual Report, including details of its members and meetings, sits within the IHPA Annual Report, at p33.

Jurisdictional Advisory Committee

The Jurisdictional Advisory Committee (JAC) was established under section 195 of the *National Health Reform Act 2011*. The JAC consists of a Chair appointed by the Pricing Authority and nine other members (one to represent each state, territory and the Australian Government). JAC members are appointed by written instrument by the head of the health department of each jurisdiction. The JAC met on nine occasions between 1 July 2016 and 30 June 2017.

JAC members as of 30 June 2017:

- James Downie, Chair
- Simone Corin
- Michael Pervan
- Jamin Woolcock
- Nigel Lyons
- Trevor Vivian
- Toni Cunningham
- Rob Anderson
- Helen Ceron

During the reporting period there were six JAC membership changes, with the NT, NSW, VIC and ACT advising IHPA of changes to JAC membership by written instrument.

02

Pricing Authority

Chair's welcome

It is with pleasure that I present the Independent Hospital Pricing Authority's Annual Report for 2016–17.

This year has been defined by some new and exciting challenges presented to IHPA and the Pricing Authority regarding work to provide options for pricing and funding for safety and quality in health care.

IHPA has successfully led this program of work with extensive collaboration between the Australian Commission on Safety and Quality in Health Care, clinicians, the states and territories and other key stakeholders. This resulted in the provision of robust advice to the COAG Health Council on options for the integration of safety and quality in public hospital pricing and funding.

This year has been defined by some new and exciting challenges

It is a reflection of the quality of IHPA's work that in February 2017 the Minister for Health directed IHPA to implement the three recommendations it presented to the COAG Health Council relating to sentinel events, hospital acquired complications (HACs) and avoidable readmissions. The recommendations are reflected as part of IHPA's annual pricing process in the *Pricing Framework for Australian Public Hospital Services 2017–18*.

In addition to the safety and quality work IHPA has continued to deliver its sixth round of pricing functions, further refining and improving the pricing model. We continue to see the impact that ABF is having in reducing the rate of growth in public hospital costs (see figures 3 and 4).

This year the Pricing Authority said goodbye to two of its founding members, Mr Alan Bansemer and Mr Alan Morris. I would like to thank both members for their contributions over the last five years as well as the continuing Pricing Authority members who provide expert vision and guidance.

Our achievements this year would not be possible without the input from our many stakeholders. I'd like to thank the states and territories and the Australian Government whose partnership is vital for the delivery of better health care for local communities. Also our Clinical Advisory Committee whose advice always underpins any proposed changes.

Finally, I'd like to thank James Downie, Chief Executive Officer at IHPA and all of his staff whose ability to meet new challenges demonstrates their expertise as well as the capability of IHPA to deliver high quality work in a timely manner.

I look forward to further developing work towards pricing and funding for safety and quality in health care next year as part of our ongoing role to improve the transparency of public hospital funding and strengthen incentives for efficiency in the delivery of public hospital services through the implementation of Activity Based Funding.

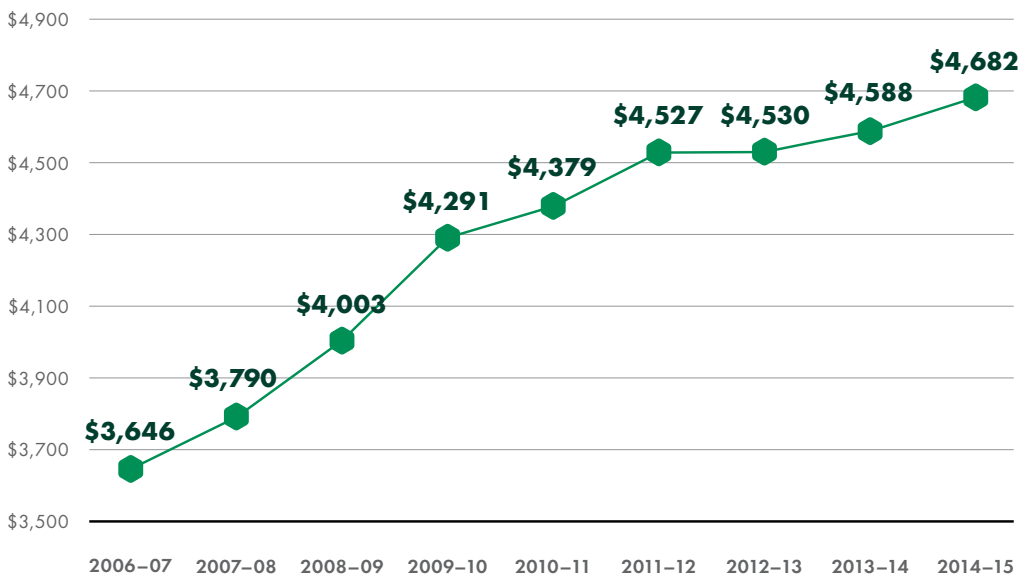
Shane Solomon
Chair, Pricing Authority
2 October 2017

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 (NEP) is determined. Figure 3 indicates a significant levelling off since the first NEP Determination in 2012, to a sustained growth rate of 1.1% since 2011–12.

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

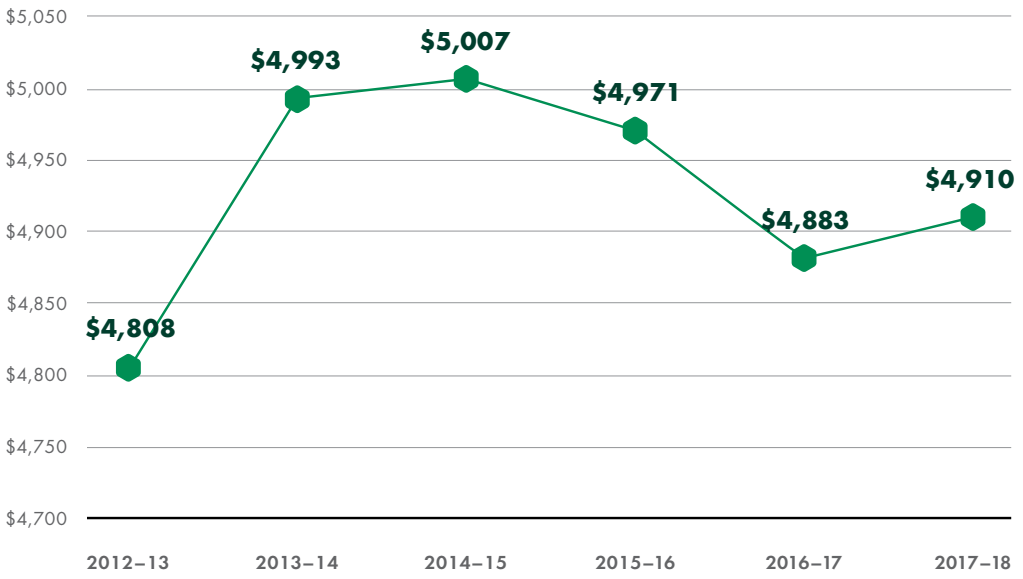


National Efficient Price

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

As required under the National Health Reform Agreement (cl B40), IHPA back-casts the NEP whenever significant changes to the methodology or underlying data occurs, to enable the fair calculation of the Australian Government's growth funding.

Figure 4: National Efficient Price 2012–2017



About the Pricing Authority

The Pricing Authority is responsible for promoting improved efficiency and access to public hospital services by providing independent advice to government 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. As of 30 June 2017, three positions were not filled.

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 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, health care 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.

The current Pricing Authority members were appointed in February 2017. Two members, Mr Alan Bansemer and Mr Alan Morris were not re-appointed on 1 February 2017.

All Pricing Authority members are non-executive.

The Pricing Authority. Back row, left to right: Mr Glenn Appleyard, Mr Jim Birch, AM (Deputy Chair), Dr Michael Walsh, Mr Alan Bansemer, Associate Professor Bruce Chater, OAM. Front row, left to right: Mr Alan Morris, Professor Jane Hall, Mr Shane Solomon (Chair).

Members of the Pricing Authority 2016–17

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 has non-executive director roles. Prior to this he was the founding Managing Director of Telstra Health, a new eHealth business within Telstra.

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 governance reforms to 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 12.

Jim Birch, AM (Deputy Chair)

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

Jim is a business consultant and was previously Global Health Leader of Ernst and Young, Lead Partner, Health and Human Services and Government and Public Sector Lead Partner at Ernst and Young. Jim has also held the position of Chief Executive of the Human Services and Health Department in South Australia.

Glenn Appleyard

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

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

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

Alan Bansemer

Alan Bansemer has over 42 years' experience in the health sector, including six years as the West Australian Health Commissioner and eight years as the Deputy Secretary to the Australian Government Department of Human Services and Health (as it then was). He currently runs his own private consultancy group, Banscott Health Consulting Pty Ltd, providing strategic advice to health departments throughout Australia.

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 and the Australian Institute of Health and Welfare.

Associate Professor Bruce Chater, OAM

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

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

Professor Jane Hall

Professor Jane Hall is Distinguished Professor of Health Economics in the Business School at the University of Technology, Sydney. Jane 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. She established the Centre for Health Economics Research and Evaluation (CHERE) in 1990 and served as Director until 2012. She remains in the Centre as Director, Strategy. Jane is involved in health policy issues internationally through her involvement with the Commonwealth Fund International Program in Health Policy and Practice. She has held many advisory and board positions, and is currently a 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.

Alan Morris

Alan Morris is the former Chair of the Commonwealth Grants Commission and also undertakes consulting and advisory work for AusAID and the World Bank.

His prior appointments have included: Executive Director for Australia, Korea, New Zealand and Egypt at the European Bank for Reconstruction and Development, London; Secretary, Department of Premier and Cabinet, Tasmania; Secretary (Chief Executive Officer) and Secretary to Cabinet, Department of the Chief Minister, Northern Territory of Australia; Assistant to Executive Director, International Monetary Fund, Washington DC; Chief Financial Officer, International Finance Section, Australian Treasury; and First Assistant Secretary, Department of Finance, Papua New Guinea.

Dr Michael Walsh

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 has held a range of senior hospital and health department positions in Victoria and Western Australia.

Michael is Vice President of the Royal Australasian College of Medical Administration and a Fellow of the Australasian College of Health Service Management. Michael has over 25 years' experience in health service policy and management in both public and private sectors.

Meetings of the Pricing Authority 2016–17

The Pricing Authority met on 10 occasions between 1 July 2016 and 30 June 2017. Chief Executive Officer, James Downie, as the Accountable Authority, attended all ten meetings.

Table 1: Pricing Authority meetings and attendances 2016–17

MEMBER	MEETINGS ELIGIBLE	MEETINGS ATTENDED
Shane Solomon (Chair)	10	9
Jim Birch, AM (Deputy Chair)	10	7
Glenn Appleyard	10	10
Alan Morris	6	4
Alan Bansemer	6	5
A/Prof. Bruce Chater, OAM	10	8
Prof. Jane Hall	10	10
Michael Walsh	10	9

03

IHPA 2016–17 overview

CEO's year in review

I am pleased to report on the Independent Hospital Pricing Authority's achievements in 2016–17.

This year saw IHPA complete its sixth round of annual pricing functions, publishing the *Pricing Framework for Australian Public Hospital Services 2017–18* which continues to provide a clear and stable methodology to guide our key purpose, which is to deliver the annual National Efficient Price and National Efficient Cost Determinations.

The stand out achievement of this year involved work to identify options for incorporating safety and quality into the pricing and funding of public hospital services. IHPA led this complex and highly technical piece of work in partnership with the Australian Commission on Safety and Quality in Health Care and with advice from clinicians, jurisdictions and other key stakeholders, and was able to incorporate key elements of this work for inclusion in the 2017–18 National Efficient Price Determination.

I'm looking forward to progressing work on pricing and funding for safety and quality in 2017–18 including work to reduce the funding for hospital episodes where the patient incurs a hospital acquired complication, such as a hospital associated infection or a fall resulting in a fracture, as well as consultation regarding approaches to pricing and funding avoidable hospital readmissions.

In 2016 IHPA launched the national benchmarking portal enabling staff throughout the public hospital system to compare hospital-level cost and activity data across the country. This will also provide an important way to benchmark safety and quality measures going forward.

2016–17 snapshot

July

National benchmarking portal launched

August

Direction from Minister for Health to provide COAG Health Council with advice on options for pricing and funding for safety and quality

September

James Downie appointed IHPA Chief Executive Officer

Consultation on *Pricing Framework for Australian Public Hospital Services 2017–18* released

Teaching, training and research costing study published

November

Advice provided to COAG Health Council on options for pricing and funding for safety and quality

National Hospital Cost Data Collection, Round 19 finalised

Version 9.0 of the Australian Refined-Diagnosis Related Groups (AR-DRGs) released

Work to develop and refine health care classification systems has continued to make significant progress in 2016–17 with the development of a new emergency care classification, refinements to the Australian Mental Health Care Classification and development of the first version of the Australian teaching and training classification which will be made available for public consultation in August 2017. Demonstrating our growing capability and maturity as an organisation, IHPA began work to bring the Australian Refined-Diagnosis Related Groups (AR-DRGs) classification work in-house this year.

Recognising the critical importance that data plays in IHPA's work, this year saw the successful design and implementation of a new highly secure, cloud-based data facility that will ensure IHPA remains at the forefront of data security and capability for many years to come.

I am looking forward to October 2017 which will see the culmination of much hard work to bring together our annual conference which this year will take on an international component. The five-day event will be held in collaboration with Patient Classification Systems International in Sydney with a focus on 'value based health care'.

I would like to express my gratitude to the Pricing Authority and the Clinical Advisory Committee for their expert guidance through some new and exciting challenges this year. In particular, I would like to thank both Alan Morris and Alan Bansemer for the significant contribution they have made to the Pricing Authority in its first five years, and wish them well for the future.

Finally, I'd like to thank the IHPA staff who continue to produce outstanding work. Our achievements this year are a testament to staff across all levels of IHPA and demonstrate our ongoing commitment to improving health care services across Australia.

James Downie
Chief Executive Officer, IHPA
2 October 2017

February

Direction from Minister for Health to implement recommendations agreed by COAG Health Council for pricing and funding for safety and quality

March

Pricing Framework for Australian Public Hospitals 2017–18 published

National Efficient Price and National Efficient Cost Determinations for 2017–18 published

May

Consultation on Work Program 2017–18

June

Three year data plan updated

Publication of *IHPA Work Program 2017–18*

04

Clinical Advisory Committee

Annual Report

Letter from the Chair

I am delighted to present the Clinical Advisory Committee's (CAC) Annual Report for 2016–17.

This year the CAC has continued to provide input into the *Pricing Framework for Australian Public Hospital Services* ensuring that IHPA continued to deliver a clinically relevant National Efficient Price and National Efficient Cost Determination for 2016–17.

The CAC played an important role in providing clinical input into the options for pricing and funding for safety and quality that IHPA presented to the COAG Health Council in November 2016. This work included continued participation on the joint working party with the Australian Commission for Safety and Quality in Health Care to refine work on hospital acquired complications and to look at ways in which data routinely generated in Australian public hospitals can be provided to clinical teams in hospitals to promote improvements to safety and quality.

We continued to advise on the development of national classification systems for emergency care, teaching and training and mental health care as well as continued refinements to the classifications for acute admitted care with development of the Tenth Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and the release of Version 9.0 of the Australian Refined-Diagnosis Related Groups (AR-DRGs).

We continued to advise on the development of national classification systems

The CAC also provided significant input into options for bundled pricing across different care settings for future years.

I would like to thank my fellow CAC members for their contribution to the work outlined within this chapter. The CAC is a multidisciplinary group comprising experts in their areas that bring a great deal of high-level knowledge not only in relation to clinical practice, but also to funding.

I would also like to acknowledge the Pricing Authority and the IHPA CEO and staff for successfully delivering its Work Program for 2016–17. I look forward to continuing to lead the work of the CAC for the coming year.

Associate Professor Alasdair MacDonald
Chair, Clinical Advisory Committee
2 October 2017

About the Clinical Advisory Committee

The Clinical Advisory Committee (CAC) members provide high-level technical and clinical advice to the Pricing Authority on a range of issues such as Activity Based Funding and classification development and revision to guide IHPA policy development and inform the National Efficient Price and National Efficient Cost.

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

The functions of the CAC are described in s 177:

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

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

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

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

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

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

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

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

Membership

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

Table 2: Membership and meetings of the CAC in 2016–17

Name	Position	Specialty	Meetings eligible	Meetings attended
A/Prof. Alasdair MacDonald	Chair	Internal Medicine	5	5
Prof. Gerard Carroll	Member	Cardiology/Rural	5	2
Prof. Peter Macdonald	Member	Transplantation	5	0
A/Prof. Paul Varghese	Member	Geriatrics/Rehabilitation	5	4
Dr Bernard Whitfield	Member	Ear Nose and Throat Surgery/ Injuries/Trauma	5	4
Prof. John Turnidge	Member	Infectious Disease	5	0
Dr Philip Hoyle	Member	Administration	5	3
A/Prof. Louis Irving	Member	Respiratory/ Indigenous Health	5	3
A/Prof. Daryl Williams	Member	Anaesthesia and Pain Management	5	4
Prof. Leon Flicker	Member	Geriatrics/Indigenous Health	5	4
W/Prof. Fiona Wood	Member	Burns	5	3
Dr Amanda Ling	Member	Administration	5	3
A/Prof. Liza Heslop	Member	Nursing/Pregnancy and Childbirth	5	4
Prof. Graham J Reynolds	Member	Paediatrics	5	5
Prof. Geoff Donnan	Member	Neurology	5	1
Jan Erven	Member	Occupational Therapist	5	4
Prof. Sally Tracy	Member	Midwife	5	0
Amber Polles (nee Roberts)	Member	Pharmacist	5	5
Dr Ruth Vine	Member	Psychiatrist	5	0
Sue Davis	Member	Nurse	5	3
Dr Jo Wright	Member	Rural Medical Practice	5	1
A/Prof. Melinda Truesdale	Member	Emergency Medicine	5	4
Dr Amod Karnik	Member	Intensive Care Medicine	5	2
A/Prof. Andrew Wei	Member	Haematology	5	4
Anthony Graham Fish	Member[1]	Allied Health	1	0
Dr Kathryn Zeitz	Member[2]	Nurse	1	0

[1] Dr Kathryn Zeitz was appointed to the IHPA Clinical Advisory Committee effective 21 February 2017.
[2] Anthony Graham Fish was appointed to the IHPA Clinical Advisory Committee effective 6 March 2017.

2016–17 snapshot

In 2016–17 the Clinical Advisory Committee supported IHPA's Work Program to deliver the following key achievements:

- Advice and input into options for pricing and funding for safety and quality.
- The *Pricing Framework for Australian Public Hospital Services 2017–18*.
- IHPA's determination of the NEP and NEC for 2017–18.
- Development of a new classification system for teaching and training.
- Work to develop a new classification system for emergency care services.
- Released version 9.0 of the Australian Refined-Diagnosis Related Groups (AR-DRGs).
- Creation of educational animation to assist clinicians in understanding the importance of diagnoses information in medical records.

CAC meetings 2016–17

15 August 2016
21 September 2016
22 November 2016
13 February 2017
8 May 2017

05

Management and accountability

Key corporate governance practices

Since formation of the agency 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 obligations defined in the *National Health Reform Act 2011* are overseen by the Pricing Authority. The Pricing Authority provides guidance and approval on IHPA's core business activities—ABF classification development and pricing products.

Risk management

IHPA's enterprise approach to risk management is administered using tools that deal with strategic and tactical risks.

Strategic risks are developed with reference to current business and environmental issues facing IHPA. At 30 June 2017, there were nine strategic risks under active management. These risks include: data management, maintenance of independence, classification development, compliance and corporate risks. These strategic risks are actively managed through audits, assurance and control processes. Where new risks emerge, resources are assigned to understand and manage the risks.

Tactical risks are managed through a decision based risk management tool. This is a particularly useful process in regards to procurement and information and communication technology (ICT) risks, as it enables them to be quickly documented and a position determined on the managed risk likelihood and consequence. Through this approach, management is fully cognisant of managed risk outcomes during its decision making.

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

Compliance

IHPA has a broad range of compliance obligations including key statutory obligations set out in the *National Health Reform Act 2011* and the National Health Reform Agreement, the *Public Governance Performance and Accountability Act 2013* (the PGPA Act) and the Public Governance Performance and Accountability Rule 2014. Other legal and compliance obligations include those relating to employees, work health and safety, privacy, freedom of information, intellectual property, the Protective Security Policy Framework, website accessibility and records management.

The Accountable Authority received 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 Crowe Horwath, the independent internal auditor.

Compliance achievements during the year include:

- ICT systems assessed as compliant with the top risks defined by Australian Signals Directorate
- IHPA confirmed to the relevant Ministers its full compliance with the Protective Security Policy Framework of the Commonwealth
- There were no compliance issues arising from IHPA's administration of relevant sections of the *National Health Reform Act 2011*
- IHPA did not report any material compliance issues emanating from the *Public Governance Performance and Accountability Act 2013*
- Third-party audit by Crowe Horwath on internal governance and management of Pricing Authority protected data, with a positive result.

Financial authorisation

IHPA makes procurement decisions in accordance with the Commonwealth Procurement rules. Line managers have value and purchase class limits in accordance with a delegation of financial authorities that is approved by the Accountable Authority.

Audit, Risk and Compliance Committee

The IHPA Audit, Risk and Compliance (ARC) Committee provides independent advice to assist the Chief Executive Officer, the Executive Committee and the Pricing Authority manage IHPA's financial and business risk.

At 30 June 2017 members of the ARC Committee comprised:

- Robert Butterworth, Chair and Independent member
- Angela Diamond, Independent member
- Alan Bansemer, Independent member.

Fraud control plan

IHPA's fraud control plan is recognised as a critical internal tool used to mitigate the act and consequences of unauthorised use of IHPA data and financial resources. 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.

Inter-agency financial activity

During the 2016–17 financial year IHPA received shared services resourcing from the Department of Health. The Department of Health charged IHPA $0.414 million 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

In 2016–17, IHPA's staff transferred to the Department of Health and seconded back to IHPA as part of machinery of government changes.

The Department of Health will report on IHPA staff as part of its staffing numbers, however to ensure transparency IHPA will report separately on those staff who have been seconded to IHPA and report to the IHPA Chief Executive Officer.

Table 3: Staff numbers by classification, gender and full-time/part-time status at 30 June 2017

	FEMALE			MALE			
CLASSIFICATION	TOTAL	F/T	P/T	TOTAL	F/T	P/T	TOTAL
HOPO	0	0	0	1	1	0	1
SES	1	1	0	0	0	0	1
EL2	3	3	0	4	4	0	7
EL1	8	6	2	9	9	0	17
APS Level 6	9	5	4	5	5	0	14
APS Level 5	1	1	0	0	0	0	1
APS Level 3	0	0	0	1	1	0	1
TOTAL	22	16	6	20	20	0	42

Key: F/T = full time, P/T = part time, HOPO = Holder of Public Office (a statutory appointment—the CEO)
Note: Staff numbers by classification are based on actual not nominal classification.

Staff training

Training was provided on a programmed basis to management and a needs basis to individual staff.

IHPA supported individuals to attend conferences and training events that assisted them to acquire and develop skills used in their work. In 2016–17, IHPA's training investment averaged $3,600 per staff member.

With the transfer of IHPA staff to the Department of Health, opportunities for staff training and development have increased with access to the Department of Health's significant training resources.

The Accountable Authority—education and review processes

Under the *National Health Reform Act 2011*, the Chief Executive Officer is the Accountable Authority. During the reporting period the CEO enhanced his skills through attendance at domestic and international Activity Based Funding events and attended specialised leadership training that was also made available to IHPA mid-level and senior management staff. The CEO receives regular performance feedback via the monthly Pricing Authority meetings.

Work, Health and Safety (WHS)

In 2016–17, 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 three times during the year and dealt with a range of WHS matters.

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

In 2016–17 no notifiable incidents were identified in regards to WHS. No workers reported injuries and no worker compensation claims were made. There were no investigations conducted during the year relating to businesses or undertakings conducted by the entity.

Advertising and market research

In 2016–17 IHPA commissioned the following advertising that must be reported under s 311A of the *Commonwealth Electoral Act 1918*.

Consultation Paper on Pricing Framework for Australian Public Hospital Services 2017–18 —Dentsu Mitchell Media Australia Pty Ltd— $17,785.47

06

Annual performance statements

Introductory statement

I, James Downie, as the Accountable Authority of the Independent Hospital Pricing Authority (IHPA), present the 2016–17 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.

IHPA purpose

Under the *National Health Reform Act 2011*, IHPA has one purpose: providing independent advice to governments in relation to the efficient costs of public hospital services, and developing and implementing robust systems to support Activity Based Funding for such services.

IHPA has one outcome: to promote improved efficiency in, and access to, public hospital services.

Results

Activity 1: Perform IHPA pricing functions

IHPA's primary function is to produce the National Efficient Price (NEP) and the National Efficient Cost (NEC) each year. The National 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 next financial year. The Pricing Framework forms the policy basis for the NEP and NEC determinations.

During 2016–17, IHPA was to undertake further technical development to improve the price setting process, and continue to refine the models used to determine the NEP and NEC.

Criteria:

1. Publish the *Pricing Framework for Australian Public Hospital Services 2017–18* by 31 December 2016.
2. Publish the NEP and NEC Determinations by 31 March 2017.
3. Reduction in the range between the 50th and 90th percentile cost per NWAU when compared to 2014–15 data.

Source:

- 2016–17 Corporate Plan—Strategy 1
- 2016–17 Portfolio Budget Statement Program 1.1

Result against performance criteria:

1. This year the *Pricing Framework for Australian Public Hospital Services 2017–18* was published alongside the National Efficient Price and National Efficient Cost Determinations on 6 March 2017. This was a strategic decision reflecting the detailed work IHPA undertook to identify and investigate a variety of options for incorporating safety and quality into the pricing and funding of public hospital services for National Efficient Price for 2017–18. IHPA will return to releasing the Pricing Framework ahead of the Determinations in future years.
2. The NEP and NEC Determinations were published on time, in March 2017.
3. There has been no significant change in the range between the 50th and 90th percentile cost per NWAU.

Activity 2: Develop national classifications for Activity Based Funding

ABF requires robust classification systems. Classifications aim to provide the health care sector with a nationally consistent method of classifying all types of patients, their treatment, and associated costs. IHPA has already determined the national classifications systems for public hospital services, including admitted acute, non-admitted, emergency and subacute care. Classifications are reviewed regularly and updated periodically to ensure that they remain clinically relevant and resource homogenous within a service category. Such modifications are based on robust statistical analysis and include specialist input from clinicians.

During 2016–17, IHPA aimed to further develop the classifications for admitted acute care, subacute care and non-admitted patient care as well as progress the initial design and development of new classifications in emergency care, teaching and training and mental health care.

Criteria:

1. Continue development work on the new classification system for emergency care services in 2016–17.
2. Implementation of the Australian Mental Health Care Classification (AMHCC) V1.0 from June 2016.
3. Ongoing development of the subacute care classification.
4. Complete new classification teaching, training and research.
5. Continue development work on the new classification for non-admitted care.
6. Continue development work on Australian Modification of the International Statistical Classification of Diseases 10th Edition and the Australian Refined Diagnosis Related Groups Version 9.0 for release prior to 30 June 2017.
7. Provide a further increase in the proportion of funding for public services using ABF as reported by the Administrator of the National Health Funding Pool.

Source:

- 2016–17 Portfolio Budget Statement Program 1.1

Result against performance criteria:

1. Development of the new emergency care classification continued in 2016–17 with the finalisation of a data set comprising of costed activity data. Preliminary analysis using the costed data set allowed work to commence on developing options for the new classification structure.
2. In 2016–17 IHPA continued to refine the AMHCC for the next iteration, Version 2.0. The Inter-rater reliability study on the concept of mental health phase of care was completed successfully. It clearly demonstrated the areas required for future refinement and provided IHPA with a clear path for future development. IHPA will undertake further investigation with a clinical complexity review and clinical refinement project.

3. IHPA continued further refinement of the Australian National Subacute and Non-Acute Patient (AN-SNAP) Version 4 classification in 2016–17, with analysis and consultation focusing on the geriatric evaluation and management branch for the purposes of the development of AN-SNAP Version 4.1.
4. IHPA commenced development of the Australian teaching and training classification using the data from the teaching, training and research costing study, and targeted consultation with key stakeholders. The first version of the classification will be made available for public consultation in August 2017.
5. IHPA has continued development of the Australian Non-Admitted Care Classification (ANACC). Scoping work, data analysis and development of non-admitted classification structures and variables continued into 2016–17, with a stakeholder consultation paper due for release in the second half of 2017.
6. Refinement of the classifications for acute admitted care continued with development of the Tenth 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 Australian Coding Standards (ACS) implemented 1 July 2017. Version 9.0 of the Australian Refined-Diagnosis Related Groups (AR-DRGs) was also developed and released during 2016–17 and will be used for pricing admitted acute episodes of care from 1 July 2018. Refinements were undertaken following clinical and statistical analysis and in consultation with clinicians, jurisdictions and other health sector stakeholders to ensure that the classifications remain current, clinically relevant and adequately explain the costs of providing admitted acute hospital care.
7. As of May 2017, 84.48% of funding for public services paid by the Administrator of the National Health Funding Pool was ABF. This is an increase of 2% from 2013–14.

Table 4: Proportion of funding for public hospital services using ABF

Year	Percent
2013–14	82.43%
2014–15	83.08%
2015–16	85.42%
2016–May 17	84.48%

Activity 3: Determine data requirements and data standards

Timely, accurate and reliable public hospital data is vital to both the development of classifications for hospital services and to determine the NEP 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 every six months to indicate jurisdictional compliance with the specifications in the rolling Three Year Data Plan.

Criteria:

1. Update rolling Three Year Data Plan and publish on IHPA website by July 2016.
2. Publication of a report on a six monthly rolling basis outlining compliance with the data requirements and data standards specified in the rolling Three Year Data Plan.
3. Internal data assessment and compliance.
4. Assurance from jurisdictions regarding data quality/accuracy.

Source:

- 2016–17 Corporate Plan—Strategy 4
- 2016–17 Portfolio Budget Statement Program 1.1

Result against performance criteria:

1. The Three Year Data Plan was updated and published on the IHPA website in June 2016.
2. The biannual data compliance reports were consulted on with jurisdictions and published on the IHPA website.
3. ABF data submissions were assessed based on the published data standards such as data set specification and data request specification. The 2016 IHPA Data Compliance Policy was used to assess jurisdictional compliance rating.
4. Jurisdictions were required to sign off their final data submission to IHPA to ensure that data conforms as closely as is achievable in regards to its quality and accuracy.

Activity 4: 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.

Criteria:

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

Source:

- 2016–17 Portfolio Budget Statement Program 1.1

Result against performance criteria:

1. An updated *Cost-Shifting and Cross-Border and Dispute Resolution Framework* (Version 3.10) was published in May 2017.
2. In 2016–17 IHPA did not receive any requests relating to this function.

Activity 5: 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.

The methodology that underpins IHPA's decisions and Work Program is informed by extensive consultation with governments and stakeholders. 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.

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 wide audience in the health industry.

Source:

- 2016–17 Corporate Plan
- 2016–17 Work Program

Results against performance criteria:

1. In 2016–17 IHPA maintained up to 17 committees and working groups to provide expert advice and to ensure the transparency and integrity of the organisation. During the reporting period IHPA held 77 meetings with the various committees and working groups.
2. IHPA conducted three public consultation processes in 2016–17, each in accordance with the *National Health Reform Act 2011*. These included:
   i. *Pricing Framework for Australian Public Hospital Services* 2017–18 (October 2017)
   ii. IHPA Work Program (June 2017)
   iii. Public consultation on the new version of the Australian Refined-Diagnosis Related groups (AR-DRG) Classification System, including ICD-10-AM/ACHI/ACS Tenth Edition and AR-DRG Version 9.0 (August 2016).
4. All submissions received by IHPA were presented to the Pricing Authority for consideration and published on the IHPA website.
5. IHPA received 82 inbox enquiries during the reporting period. 85% were responded to within two weeks, and 42% of those were responded to on the day of receipt.

Table 5: Response rate to enquiries 1 July 2016 – 30 June 2017

Total Requests	Same day response	1–7 days	7–14 days	15+ days
82	28	32	17	5

Analysis

IHPA has had another very productive year, meeting its performance criteria as well as deliverables in the *IHPA Work Program 2016–17.*

A major focus this year has been the work towards pricing and funding for safety and quality. IHPA has been able to meet these challenges in a professional and timely manner, while continuing to achieve the criteria set out in its annual Work Program.

The *IHPA Work Program 2016–17* 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 published on the IHPA website (see www.ihpa.gov.au/publications). To keep track of its Work Program deliverables, IHPA produces a fortnightly ABF Project Status Report, which covers all Work Program deliverables up to and during that period. The Status Report for the period ending 1 July 2017 indicated all relevant projects were completed, or on schedule.

The Australian Refined-Diagnosis Related Groups classification continues to be well-regarded within Australia and internationally and is currently licensed for use in 18 countries around the world.

During the last financial year IHPA launched the national benchmarking portal enabling staff throughout the public hospital system to compare hospital-level cost and activity data across the country. This will also provide an important way to benchmark safety and quality measures going forward.

This year saw the successful design and implementation of a new highly secure, cloud-based data facility that will ensure IHPA remains at the forefront of data security and capability for many years to come. Going forward, this will reduce the work required by jurisdictions in submitting data to IHPA while ensuring high quality data is provided.

The National Efficient Price and National Efficient Cost Determinations for 2017–18 continue to demonstrate the benefits of Activity Based Funding in reducing costs (see p21).

07

Financial management

ANAO report

INDEPENDENT AUDITOR'S REPORT

To the Miniter for Health

Opinion

In my opinion, the financial statements of the Independent Hospital Pricing Authority for the year ended 30 June 2017:

(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 Independent Hospital Pricing Authority as at 30 June 2017 and its financial performance and cash flows for the year then ended.

The financial statements of the Independent Hospital Pricing Authority, which I have audited, comprise the following statements as at 30 June 2017 and for the year then ended:

- Statement by the Chief Executive 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 Independent Hospital Pricing Authority 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* to the extent that they are not in conflict with the *Auditor-General Act 1997* (the Code). I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the Independent Hospital Pricing Authority the Chief Executive Officer is responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under that Act. The Chief Executive Officer is also responsible for such internal control as the Chief Executive Officer determines is necessary to enable the preparation and fair presentation 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 Independent Hospital Pricing Authority's ability 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 matters related to going concern

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as applicable 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

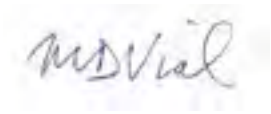
My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that 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 those charged with governance 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



Mark Vial
Senior Director

Delegate of the Auditor-General

Canberra

26 September 2017

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Independent Hospital Pricing Authority Financial Statements 2016–17

For the year ended 30 June 2017

STATEMENT BY THE CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER

In our opinion, the attached financial statements for the year ended 30 June 2017 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.

Signed
James Downie
Chief Executive Officer
22 September 2017

Signed
Craig Boyd
Chief Financial Officer
22 September 2017

Statement of Comprehensive Income

for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
NET COST OF SERVICES				
EXPENSES				
Employee benefits	1.1A	5,728	8,019	5,975
Suppliers	1.1B	11,015	14,367	16,282
Depreciation and amortisation	2.2A	533	671	800
Finance costs	1.1C	21	3	-
Write-down and impairment of assets	1.1D	74	-	-
Total expenses		**17,371**	**23,060**	**23,057**
OWN-SOURCE INCOME				
Own-source revenue				
Sale of goods and rendering of services	1.2A	909	867	16,383
Interest		125	133	34
Other revenue	1.2B	5,485	163	6,640
Total own-source revenue		**6,519**	**1,163**	**23,057**
Gains				
Other gains	-	-	-	-
Total gains		**-**	**-**	**6,640**
Total own-source income		**6,519**	**1,163**	**23,057**
Net cost of services		**(10,852)**	**(21,897)**	**-**
Revenue from Government	1.2C	13,538	25,877	-
Surplus		**2,686**	**3,980**	**-**
Other comprehensive income				
Changes in asset revaluation surplus		**72**	**-**	**-**
Total comprehensive surplus		**2,758**	**3,980**	**-**

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

Budget Variances Commentary

Statement of Comprehensive Income

Employee benefits of $5.728m were lower than the budgeted amount of $5.975m due to lower than budgeted staffing levels. Supplier expenses of $11.015m were also down from the budgeted amount of $16.282m principally through a reduction in expenditure on contractors and consultants. These reductions were attributable to more mature business processes as well as a rephasing of activities into the 2017–18 year. This also contributed to the reduction of total own-source revenue, being $6.519m in comparison to the budgeted amount of $23.057m.

The 2016–17 free of charge services contributed by the Department of Health was lower than the budgeted level by $1.55m which is disclosed as other revenue (Note 1.2B).

Statement of financial position

as at 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	2.1A	9,793	8,400	3,593
Trade and other receivables	2.1B	211	18,515	20,287
Total financial assets		**10,004**	**26,915**	**23,880**
Non-financial assets				
Buildings	2.2A	201	395	68
Plant and equipment	2.2A	342	360	262
Computer software	2.2A	2	184	-
Internally developed software	2.2A	732	-	-
Other intangibles	2.2A	114	172	307
Other – prepayments		255	49	48
Total non-financial assets		**1,646**	**1,160**	**685**
Total assets		**11,650**	**28,075**	**24,565**
LIABILITIES				
Payables				
Suppliers	2.3A	2,543	1,931	3,397
Other payables	2.3B	109	787	677
Total payables		**2,652**	**2,718**	**4,074**
Provisions				
Employee provisions	4.1A	123	1,085	-
Other provisions	2.4	186	165	170
Total provisions		**309**	**1,250**	**170**
Total liabilities		**2,961**	**3,968**	**4,244**
Net assets		**8,689**	**24,107**	**20,321**
EQUITY				
Contributed equity		400	400	400
Reserves		88	16	16
Retained surplus		8,201	23,691	19,905
Total equity		**8,689**	**24,107**	**20,321**

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

Budget Variances Commentary

Statement of Financial Position

Total financial assets of $10.004m were lower than the budget of $23.880m principally as a result of the lapsing receivable from Government of $18.176m which was partially offset by the increase in cash and cash equivalents balances of $6.200m compared to budget

Non-financial assets at $1.646m were higher than budget principally due to the development and the capitalisation of new information technology infrastructure.

Total equity of $8.689m compared to a budget of $20.321m is impacted by the lapsing receivable from Government, offset in part by the surplus for the reporting period.

Statement of changes in equity

for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'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**
RETAINED EARNINGS				
Opening balance				
Balance carried forward from previous period		23,691	19,711	19,905
Transaction with owners				
Reduction in receivable from Government		(18,176)	-	-
Comprehensive income				
Surplus for the period		2,686	3,980	-
Closing balance as at 30 June		**8,201**	**23,691**	**19,905**
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		16	16	16
Comprehensive income				
Other comprehensive income		72	-	-
Closing balance as at 30 June		**88**	**16**	**16**
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		24,107	20,127	20,321
Transaction with owners				
Reduction in receivable from Government		(18,176)	-	-
Comprehensive income				
Surplus for the period		2,686	3,980	-
Other comprehensive income		72	-	-
Closing balance as at 30 June		**8,689**	**24,107**	**20,321**

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

Accounting Policy

Receivable from Government
Funding receivable from non-corporate Commonwealth entities was recognised as Revenue from Government. The receivable from Government has now lapsed and is therefore reported as a reduction to Retained Earnings.

Budget Variances Commentary

Statement of Changes in Equity
Total equity of $8.689m compared to a budget of $20.321m is impacted by the lapsing receivable from Government of $18.176m and in part offset by the surplus for the period.

Cash Flow Statement

for the period ended 30 June 2017

	Notes	2017 $'000	2016 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Receipts from Government		13,538	26,120	15,296
Sale of goods and rendering of services		851	1,994	526
Interest		125	133	34
Net GST received		186	1,132	1,628
Other		62	105	-
Total cash received		**14,762**	**29,484**	**17,484**
Cash used				
Employees		1,283	8,271	6,920
Suppliers		11,249	17,020	11,374
Net GST paid		-	105	84
Other		-	1	81
Total cash used		**12,553**	**25,397**	**18,459**
Net cash from operating activities	3	**2,209**	**4,087**	**(975)**
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment		39	199	417
Purchase of internally developed software		777	-	-
Purchase of computer software		-	231	-
Total cash used		**816**	**430**	**417**
Net cash used by investing activities		**(816)**	**(430)**	**(417)**
Net increase in cash held		**1,393**	**3,657**	**(1,392)**
Cash and cash equivalents at the beginning of the reporting period		8,400	4,743	4,985
Cash and cash equivalents at the end of the reporting period	2.1A	**9,793**	**8,400**	**3,593**

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 at 30 June 2017 was $9.793m, being $6.200m higher than the budgeted amount principally through net cash from operating activities of approximately $3.184m and a higher amount of cash on hand at the beginning of the reporting period of $3.415m. These two factors were in part offset by higher cash used by investing activities, principally as a result of the investment made in new information technology infrastructure.

Overview

Objectives of the Independent Hospital Pricing Authority

The Independent Hospital Pricing Authority (IHPA) is an Australian Government controlled, not-for-profit entity and is a Corporate Commonwealth Entity under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

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

IHPA's functions include, to:

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

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

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

The Basis of preparation

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

The financial statements have been prepared in accordance with the:

a. Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR) for reporting periods ending on or after 1 July 2015; 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 2016–17

As announced in the in the 2015–16 *Mid Year Economic and Fiscal Outlook*, the Government transferred the operational functions of IHPA to the Department of Health from 1 July 2016. The Board, Chief Executive Officer and associated functions were retained by IHPA.

New Australian Accounting Standards

Adoption of new Australian Accounting Standard requirements

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

During the period, the Department adopted AASB 124 Related Party Transactions which is reported in Note 4.2: Key Management Personnel and Note 4.3: Related Party Transactions.

Future Accounting Standard requirements

The following new, revised and amending standards or interpretations were issued by the AASB prior to the signing of the statement by the Chief Executive Officer and Chief Financial Officer, for which the Pricing Authority is still assessing the potential impact on the financial statements:

1. AASB 9 *Financial Instruments*;
2. AASB 15 *Revenue from Contracts with Customers*;
3. AASB 16 *Leases*; and
4. AASB 1058 *Income of Not-for-Profit Entities*.

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

Significant accounting judgements and estimates

Except where specifically identified and disclosed, the Pricing Authority 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.

Financial Performance

This section analyses the financial performance of IHPA for the year ended 2017.

Note 1.1 Expenses

	2017 $'000	2016 $'000
NOTE 1.1A: EMPLOYEE BENEFITS		
Wages and salaries	526	5,597
Superannuation		
Defined contribution plans	69	848
Defined benefit plans	2	135
Leave and other entitlements	123	1,176
Separation and redundancies	-	263
Wages and salaries for staff provided by Department of Health	5,008	-
Total employee benefits	**5,728**	**8,019**

Accounting Policy

Employee benefits

Accounting policies for employee benefits is contained in Section 4.1 People and Relationships.

	2017 $'000	2016 $'000
NOTE 1.1B: SUPPLIERS		
Goods and services supplied or rendered		
Consultants	3,443	3,653
Contractors	5,093	7,470
Travel and training costs	364	625
IT services	668	813
Publishing materials	377	203
Legal expenses and audit fees	248	224
Other	347	895
Total goods and services supplied or rendered	**10,540**	**13,883**
Goods supplied	324	926
Services rendered	10,216	12,957
Total goods and services supplied or rendered	**10,540**	**13,883**

	2017 $'000	2016 $'000
Other suppliers		
Operating lease rentals in connection with		
Minimum lease payments	469	452
Workers compensation expenses	6	32
Total other suppliers	**475**	**484**
Total suppliers	**11,015**	**14,367**

Leasing commitments

IHPA in its capacity as lessee entered into a lease for office accommodation for the period up to 31 May 2018. The lease is subject to an annual cost increase and is not able to be cancelled.

Accounting Policy

Lease incentives
Lease incentives are recognised as liabilities and reduced on a straight-line basis against rental expense over the term of the lease.

Where IHPA has a contractual obligation to undertake remedial work upon vacating a property the estimated cost is recognised as a liability.

Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:	2017 $'000	2016 $'000
Within 1 year	605	643
Between 1 to 5 years	-	605
More than 5 years	-	-
Total operating lease commitments	**605**	**1,248**

NOTE 1.1C: FINANCE COSTS

Unwinding of discount	21	3
Total finance costs	**21**	**3**

Accounting Policy

Finance costs: All finance costs are expensed as incurred.

NOTE 1.1D: WRITE-DOWN AND IMPAIRMENT OF ASSETS

Impairment of property, plant and equipment	74	-
Total write-down and impairment of assets	**74**	**-**

Accounting Policy

Impairment
All assets were assessed for impairment as at 30 June 2017. 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 1.2 Own-source revenue and gains

	2017 $'000	2016 $'000
OWN-SOURCE REVENUE		
NOTE 1.2A: SALE OF GOODS AND RENDERING OF SERVICES		
Sale of goods	374	265
Rendering of services	535	602
Total sale of goods and rendering of services	909	867

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. the Pricing Authority 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 the Pricing Authority.

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

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

	2017 $'000	2016 $'000
NOTE 1.2B: OTHER REVENUE		
Cost recovery	4	105
Departmental contribution received free of charge	5,423	-
Other resources received free of charge	58	58
Total other revenue	5,485	163

Accounting Policy

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

	2017 $'000	2016 $'000
NOTE 1.2C: REVENUE FROM GOVERNMENT		
Department of Health		
Corporate Commonwealth entity payment item	-	25,877
Amounts from related entities	13,538	-
Total revenue from Government	**13,538**	**25,877**

Accounting Policy

Revenue from Government

Funding received or receivable from non-corporate Commonwealth entities is recognised as Revenue from Government by the Pricing Authority 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

	2017 $'000	2016 $'000
NOTE 2.1A: CASH AND CASH EQUIVALENTS		
Cash on hand or on deposit	9,793	8,400
Total cash and cash equivalents	**9,793**	**8,400**

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.

	2017 $'000	2016 $'000
NOTE 2.1B: TRADE AND OTHER RECEIVABLES		
Appropriations receivables		
Receivable from Government	-	18,176
Total appropriations receivables	**-**	**18,176**
Other receivables		
GST receivable from the Australian Taxation Office	83	269
Other amounts receivable	128	70
Total other receivables	**211**	**339**
Total trade and other receivables (gross)	**211**	**18,515**
Less impairment allowance	**-**	**-**
Total trade and other receivables (net)	**211**	**18,515**
Trade and other receivables (net) expected to be recovered		
No more than 12 months	211	18,515
More than 12 months	-	-
Total trade and other receivables (net)	**211**	**18,515**

No amounts receivable are overdue.

Accounting Policy

Loans and Receivables
Trade receivables, loans and other receivables that have fixed or determinable payments and that are not quoted in an active market are classified as 'loans and receivables'. Loans and receivables are measured at amortised cost using the effective interest method less impairment.

Collectability of debts is reviewed as at the end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

Impairment
All assets were assessed for impairment as at 30 June 2017. 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

Reconciliation of the opening and closing balances of property, plant and equipment for 2017

	Buildings $'000	Plant and equipment $'000	Computer Software $'000	Internally Developed Software – in use $'000	Internally Developed Software – Work in Progress $'000	Internally Developed Software – Total $'000	Other Intangibles $'000	Total $'000
As at 1 July 2016								
Gross book value	796	632	728	-	-	-	288	2,444
Accumulated depreciation, amortisation and impairment	(401)	(277)	(545)	-	-	-	(116)	(1,333)
Total as at 1 July 2016	**395**	**360**	**184**	**-**	**-**	**-**	**172**	**1,111**
Additions								
Purchase	-	39	-	399	379	777	-	816
Depreciation and amortisation	(103)	(145)	(182)	(45)	-	(45)	(58)	(533)
Disposals								-
Non-cash consideration	-	(25)	(522)	-	-	-	-	(547)
Revaluations and impairment adjustments	(595)	(241)	-	-	-	-	-	(836)
Writeback of depreciation and other adjustments	504	354	522	-	-	-	-	1,380
Total as at 30 June 2017	**201**	**342**	**2**	**353**	**379**	**732**	**114**	**1,391**
Total as at 30 June 2017 represented by								
Gross book value	201	405	206	399	379	777	288	1,877
Accumulated depreciation, amortisation and impairment	-	63	204	(45)	-	(45)	(174)	(487)
Total as at 30 June 2017 represented by	**201**	**342**	**2**	**353**	**379**	**732**	**114**	**1,391**

The carrying amount of computer software are purchased software

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

No leasehold improvements, or property, plant and equipment or intangibles are expected to be sold or disposed of within the next 12 months.

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 at the end of the reporting period			Valuation Technique(s) and Inputs Used[2]
	2017 $'000	2016 $'000	Category (Level 1, 2 or 3)[3,4]	
Non-financial assets[1]				
Buildings	201	395	3	Valuation technique is depreciated replacement costs. Inputs used are replacement cost new (price per square metre) and consumed economic benefit/ obsolescence of asset. The weighted average range is 16.76% per annum.
Property, plant and equipment	342	360	2	Valuation technique is market approach and inputs used are adjusted market transactions.

[1] IHPA did not remeasure non-financial assets at fair value on a non-recurring basis at 30 June 2017.

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

[3] Fair value measurements — highest and best use differs from current use for non-financial assets (NFAs). IHPA's assets are held for operational purposes and not held for the purposes of deriving a profit. The current use of all controlled assets is considered their highest and best use. This is consistent with the treatment in 2016.

[4] There have been no transfers between levels of the hierarchy during the year.

Accounting Policy

Property, plant and equipment and intangibles

Assets are recorded at cost on acquisition except as stated below. The cost of 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 $2,000, 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:

	2017	2016
Leasehold improvements	Lease terms	Lease terms
Plant and equipment	3–6 years	3–6 years

Impairment

All assets were assessed for impairment at 30 June 2017. 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 (2016: 1 to 3 years).

All software assets were assessed for indications of impairment as at 30 June 2017.

Fair value measurement

IHPA undertook a comprehensive valuation of all its non-financial assets at 30 June 2017. 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. IHPA has engaged Australian Valuation Solutions (AVS) to provide written assurance that the models developed comply with AASB 13.

Note 2.3 Payables

	2017 $'000	2016 $'000
NOTE 2.3A: SUPPLIERS		
Trade creditors and accruals	2,543	1,931
Total suppliers	**2,543**	**1,931**

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

NOTE 2.3B: OTHER PAYABLES		
Payable to Department of Health	-	536
Salaries and wages	8	24
Superannuation	1	4
Lease incentive	100	209
FBT payable	-	3
Other – credit card	-	11
Total other payables	**109**	**787**

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

	Provision for restoration $'000	Total $'000
NOTE 2.4 OTHER PROVISIONS		
As at 1 July 2016	**165**	**165**
Unwinding of discount or change in discount rate	21	21
Total as at 30 June 2017	**186**	**186**

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

IHPA currently has one agreement for the leasing of premises which has provisions requiring IHPA to restore the premises to their original condition at the conclusion of the lease. IHPA has made a provision to reflect the present value of this obligation.

Funding

This section identifies the IHPA's funding structure.

Note 3.1 Cash flow reconciliation

	2017 $'000	2016 $'000
RECONCILIATION OF CASH AND CASH EQUIVALENTS AS PER STATEMENT OF FINANCIAL POSITION AND CASH FLOW STATEMENT		
Cash and cash equivalents as per		
Cash flow statement	9,793	8,400
Statement of financial position	9,793	8,400
Discrepancy	-	-
Reconciliation of net cost of services to net cash from operating activities		
Surplus	2,686	(21,897)
Revenue from Government	-	25,877
Adjustments for non-cash items		
Depreciation/amortisation	533	671
Net write down of non-financial assets	74	1
Lapsing receivable from Government	(18,176)	-
MOVEMENT IN ASSETS AND LIABILITIES		
Assets		
(Increase)/Decrease in net receivables	18,304	1,349
(Increase)/Decrease in prepayments	(205)	(1)
Liabilities		
Increase/(Decrease) in employee provisions	(962)	(55)
Increase/(Decrease) in suppliers payables	612	(1,960)
Increase/(Decrease) in other payables	(678)	99
Increase/(Decrease) in other provisions	21	3
Net cash from operating activities	2,209	4,087

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 4.1 Employee Provisions

	2017 $'000	2016 $'000
NOTE 4.1A: EMPLOYEE PROVISIONS		
Leave	123	1,085
Total employee provisions	123	1,085
Employee provisions expected to be settled		
No more than 12 months	27	318
More than 12 months	96	767
Total employee provisions	123	1,085

Accounting policy

Employee provisions
Liabilities for short-term employee benefits and termination benefits expected within twelve 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 liability for long service leave has been determined by reference to the work of an actuary as at 30 June 2017. 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 4.2 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 Portfolio Ministers, Chief Executive Officer, Executive Director (Activity Based Funding) and the Pricing Authority members.

Key management personnel remuneration is reported in the table below:

	2017 $'000	2016 $'000
Short-term employee benefits	625	789
Post-employment benefits	73	103
Other long-term benefits	39	88
Termination benefits	-	-
Total key management personnel remuneration expenses[1]	**737**	**980**

The total number of key management personnel that are included in the above table is ten (2016: ten).

[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 4.3 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 4.2 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 transations entered into during 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 5.1 Contingent Assets and Liabilities

Quantifiable Contingencies

There were no quantifiable contingent assets or liabilities in this reporting period (2016: nil)

Unquantifiable Contingencies

There were no unquantifiable contingent assets or liabilities in this reporting period (2016: nil)

Significant Remote Contingencies

There were no significant remote contingent assets or liabilities in this reporting period (2016: 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 5.2 Financial instruments

	2017 $'000	2016 $'000
NOTE 5.2A: CATEGORIES OF FINANCIAL INSTRUMENTS		
Loans and receivables		
Cash and cash equivalents	9,793	8,400
Trade and other receivables	128	70
Total loans and receivables	**9,921**	**8,470**
Total financial assets	**9,921**	**8,470**
FINANCIAL LIABILITIES		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	2,543	1,931
Payable to the Department of Health	-	536
Other payables — credit card	-	11
Total financial liabilities measured at amortised cost	**2,543**	**2,478**
Total financial liabilities	**2,543**	**2,478**

Accounting Policy

Financial assets

The entity classifies its financial assets in the following categories: financial assets at fair value through profit or loss;

a. held-to-maturity investments;

b. available-for-sale financial assets; and

c. loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are recognised and derecognised upon trade date.

Effective interest method —
Income is recognised on an effective interest rate basis except for financial assets that are recognised at fair value through profit or loss.

Financial assets at fair value through profit or loss —
Financial assets are classified as financial assets at fair value through profit or loss where the financial assets:

a. have been acquired principally for the purpose of selling in the near future;

b. are derivatives that are not designated and effective as a hedging instrument; or

c. are parts of an identified portfolio of financial instruments that the entity manages together and has a recent actual pattern of short-term profit-taking.

Assets in this category are classified as current assets.

Financial assets at fair value through profit or loss are stated at fair value, with any resultant gain or loss recognised in profit or loss. The net gain or loss recognised in profit or loss incorporates any interest earned on the financial asset.

Available-for-sale financial assets —
Available-for-sale financial assets are non-derivatives that are either designated in this category or not classified in any of the other categories.

Available-for-sale financial assets are recorded at fair value. Gains and losses arising from changes in fair value are recognised directly in reserves (equity) with the exception of impairment losses.

Interest is calculated using the effective interest method and foreign exchange gains and losses on monetary assets are recognised directly in profit or loss. Where the asset is disposed of or is determined to be impaired, part (or all) of the cumulative gain or loss previously recognised in the reserve is included in surplus and deficit for the period.

Impairment of financial assets —
Financial assets are assessed for impairment at the end of each reporting period.

Financial assets held at amortised cost —
if there is objective evidence that an impairment loss has been incurred for loans and receivables or held to maturity

investments held at amortised cost, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the Statement of Comprehensive Income.

Available for sale financial assets — if there is objective evidence that an impairment loss on an available-for-sale financial asset has been incurred, the amount of the difference between its cost, less principal repayments and amortisation, and its current fair value, less any impairment loss previously recognised in expenses, is transferred from equity to the Statement of Comprehensive Income.

Financial assets held at cost — if there is objective evidence that an impairment loss has been incurred, the amount of the impairment loss is the difference between the carrying amount of the asset and the present value of the estimated future cash flows discounted at the current market rate for similar assets.

Accounting Policy

Financial liabilities
Financial liabilities are classified as either financial liabilities 'at fair value through profit or loss' or other financial liabilities. Financial liabilities are recognised and derecognised upon 'trade date'.

Financial liabilities at fair value through profit or loss
Financial liabilities at fair value through profit or loss are initially measured at fair value. Subsequent fair value adjustments are recognised in profit or loss. The net gain or loss recognised in profit or loss incorporates any interest paid on the financial liability.

Other financial liabilities
Other financial liabilities, including borrowings, are initially measured at fair value, net of transaction costs. These liabilities are subsequently measured at amortised cost using the effective interest method, with interest expense recognised on an effective interest basis.

Supplier and other payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

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Appendix B: Acronyms and abbreviations

ABF	Activity Based Funding
AM	Member of the Order of Australia
AMHCC	Australian Mental Health Care Classification
ANAO	Australian National Audit Office
ARC Committee	Audit, Risk and Compliance Committee
AR-DRG	Australian Refined Diagnosis Related Groups
CAC	Clinical Advisory Committee
COAG	Council of Australian Governments
JAC	Jurisdictional Advisory Committee
JWP	Joint Working Party
IHPA	Independent Hospital Pricing Authority
MoG	Machinery of Government
MoU	Memorandum of Understanding
NBPD	National Benchmarking Portal Development
NEC	National Efficient Cost
NEP	National Efficient Price
NHCDC	National Hospital Cost Data Collection
NHRA	National Health Reform Agreement
NWAU	National Weighted Activity Unit
OAM	Medal of the Order of Australia
PBS	Portfolio Budget Statements
PGPA Act	*Public Governance, Performance and Accountability Act 2013*
WHS	Work Health and Safety

Appendix C: Glossary

Activity Based Funding (ABF)

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 nationally efficient prices to determine the amount of funding for each activity or service.

Australian Refined-Diagnosis Related Groups (AR-DRGs)

AR-DRGs is 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 AR-DRG 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.

Backcasting

The process by which the effect of significant changes to the ABF classification systems or costing methodologies are reflected in the pricing model the year prior to implementation, for the purpose of the calculation of Commonwealth funding for each ABF 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 (ALGA). The role of COAG is to promote policy reforms that are of national significance, or which need co-ordinated action by all Australian governments.

Corporate Plan

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

Machinery of Government (MoG)

A Machinery of Government change occurs when the Government decides to change the way Commonwealth responsibilities are managed. It can involve the movement of functions, resources and people from one agency to another.

Mid-Year Economic and Fiscal Outlook (MYEFO)

The Mid-Year Economic and Fiscal Outlook updates the economic and fiscal outlook from the previous budget and also updates the budgetary position. In particular, the MYEFO takes account of all decisions made since the release of the budget which affect expenses and revenue and hence revises the budget aggregates.

National Efficient Cost (NEC)

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

National Efficient Price (NEP)

A base price calculated by IHPA as a benchmark to guide governments about the level of funding which 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 funded programs.

National Health Reform Act 2011

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

National Health Reform Agreement

The Agreement outlines the funding, governance, and performance arrangements for the delivery of public hospital services in Australia. The Agreement was entered into by all states, territories and the Australian Government 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 presentations 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, the simplest and least expensive are worth fractions of an NWAU.

Protective Security Policy Framework (PSPF)

The PSPF 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.

Work Program

Each year IPHA consults on and publishes a Work Program for the year ahead. As prescribed in s 225 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 in accordance with Section 17BA of the Public Governance, Performance and Accountability Rule 2014, and section 46 of the *Public Governance, Performance and Accountability Act 2013*.

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Approval by the Accountable Authority	5
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Related entity transactions	n/a
Significant activities and changes affecting the entity	n/a
Judicial decisions and reviews by outside bodies	n/a
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