Annual Report

2017–18

Independent Hospital Pricing Authority

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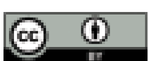

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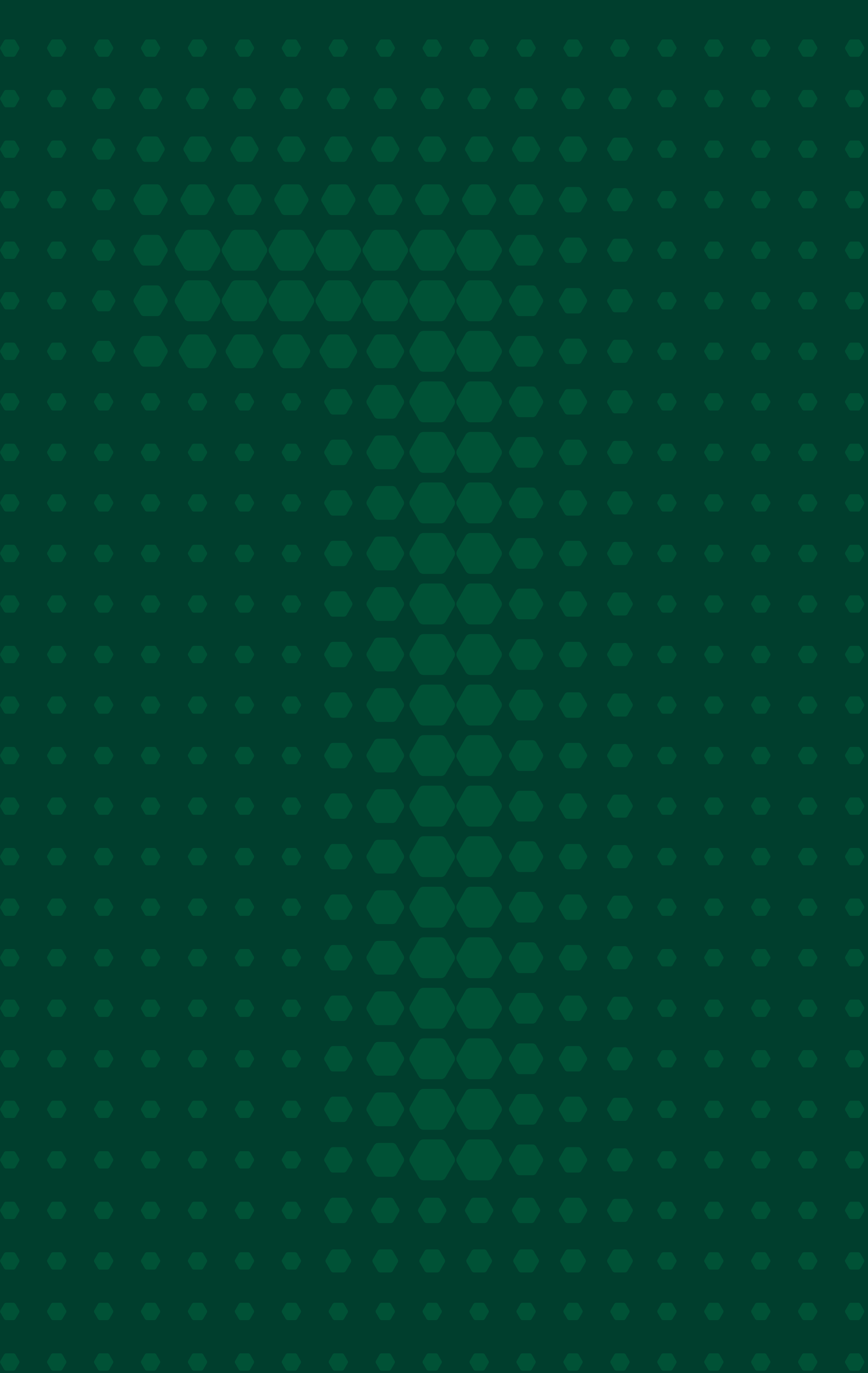
Approval by the Accountable Authority

I present the annual report of the Independent Hospital Pricing Authority for the financial year ended 30 June 2018, in accordance with the *National Health Reform Act 2011* and pursuant to section 46 of the *Public Governance, Performance and Accountability Act 2013*.

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

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

James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
28 September 2018



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

Functions and purpose

Pursuant to the *National Health Reform Act 2011*, the primary 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, and developing and implementing robust systems to support Activity Based Funding for those services. (See 'What is Activity Based Funding?', p6.)

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

Pricing and funding for safety and quality

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

This work originated from the April 2016 Council of Australian Governments' Heads of Agreement on Public Hospital Funding. In 2017, all Australian governments signed an Addendum to the National Health Reform Agreement that included the incorporation of funding and pricing approaches for safety and quality.

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

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

The implementation of pricing and funding for safety and quality is being rolled out on a staged basis. Funding adjustments related to sentinel events (such as surgical procedures involving the wrong body part or medication errors leading to death) were introduced in July 2017. Funding is reduced for any episode of admitted acute care where a hospital acquired complication occurs from July 2018. IHPA is currently developing a pricing approach for avoidable hospital admissions.

Responsible Minister

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

The Minister responsible for this reporting period is the Hon. Greg Hunt MP, Minister for Health, who was appointed on 24 January 2017 and continues in that role.

Ministerial directions and government policy orders

On 24 August 2017, IHPA received a Ministerial direction from the Hon. Greg Hunt MP, under section 226(1) of the *National Health Reform Act 2011*.

The direction required IHPA to undertake a review and, if necessary, take steps to address matters that were having an unintended effect on the calculation of efficient growth in the delivery of public hospitals services, including:

- the transfer of non-admitted care clinics from block funding arrangements to Activity Based Funding arrangements
- counting methodology changes, including the transition from some non-admitted care clinics to temporal bundling
- the impact of scope changes, including the expanded scope of the non-admitted care clinic '10.19 Ventilation-home delivered' to include patients who are dependent on ventilation at night, and who without ventilation support would be at risk of imminent hospitalisation.

The direction also requested that IHPA undertake a review and provide advice on the impact of combining patient and aggregate level data for non-admitted services in Western Australia.

In compliance with the direction, IHPA undertook the requested reviews and provided the results to Minister Hunt on 11 October 2017.

What is Activity Based Funding?

Activity Based Funding describes the process by which hospitals are paid for the number and complexity of patients they treat.

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

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

The building blocks required for an Activity Based Funding system are discussed here.

Data collection

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

Costing

Hospital costing focuses on the cost and mix of resources used to deliver patient care. Costing plays a vital role in Activity Based Funding. It is essential for understanding the total costs involved in the provision of hospital services to a patient, and assigning costs based on resource consumption. IHPA collects and reports on the National Hospital Cost Data Collection annually. This information is used for developing the classification system and for the pricing model. More information about IHPA's costing activities is available at www.ihpa.gov.au/what-we-do/costing.

Classifications

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

Pricing

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

Activity Based Funding timeline

2008

Activity Based Funding becomes a requirement of Commonwealth funding for public hospitals

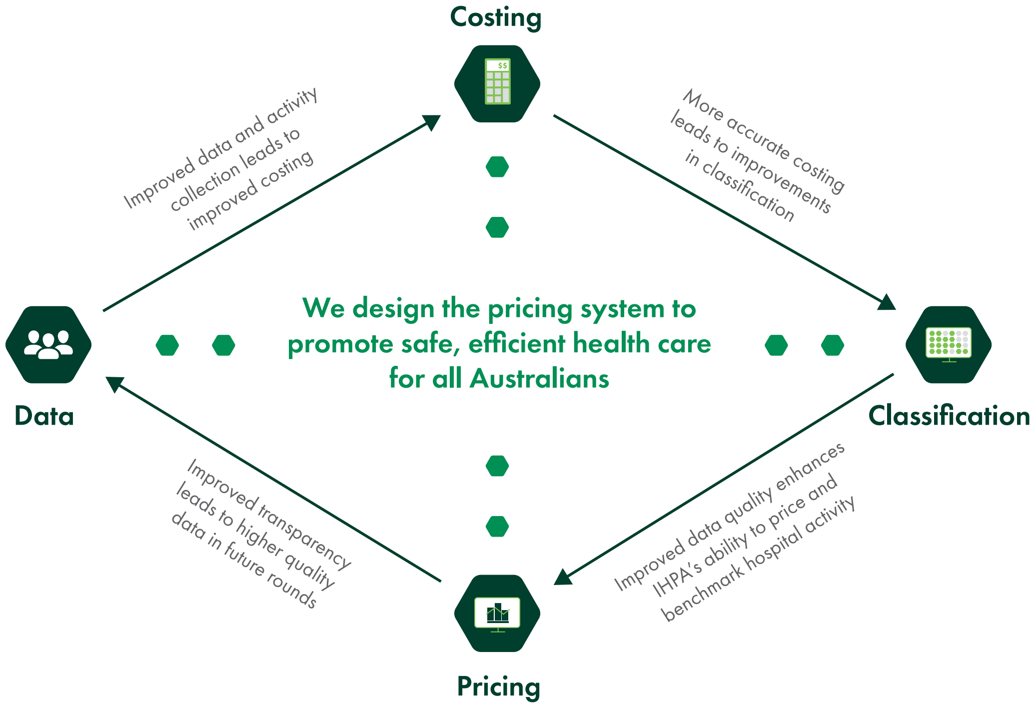
2011

National Health Reform Agreement signed by all Australian governments; this agreement outlines the establishment of IHPA

2012

First National Efficient Price was established for NEP12 at $4,808

What we do



2013

First National Efficient Cost was established for NEC13 at $4.738m

2018

Seventh National Efficient Price was established for NEP18 at $5,012

Sixth National Efficient Cost was established for NEC18 at $5.171m

How public hospital funding is determined

Volume

Block funding
A fixed amount of funding based on location, size, types of services provided, and previous funding

States and territories determine the volume and distribution of services

Activity Based Funding
A variable amount of funding based on the number of services provided to patients and the efficient cost of delivering those services

Price

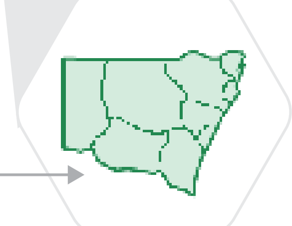
National Efficient Cost (NEC)
Average cost of block funded small rural hospitals in Australia

IHPA determines the NEC and NEP annually

National Efficient Price (NEP)
Average cost of an episode of care in a public hospital

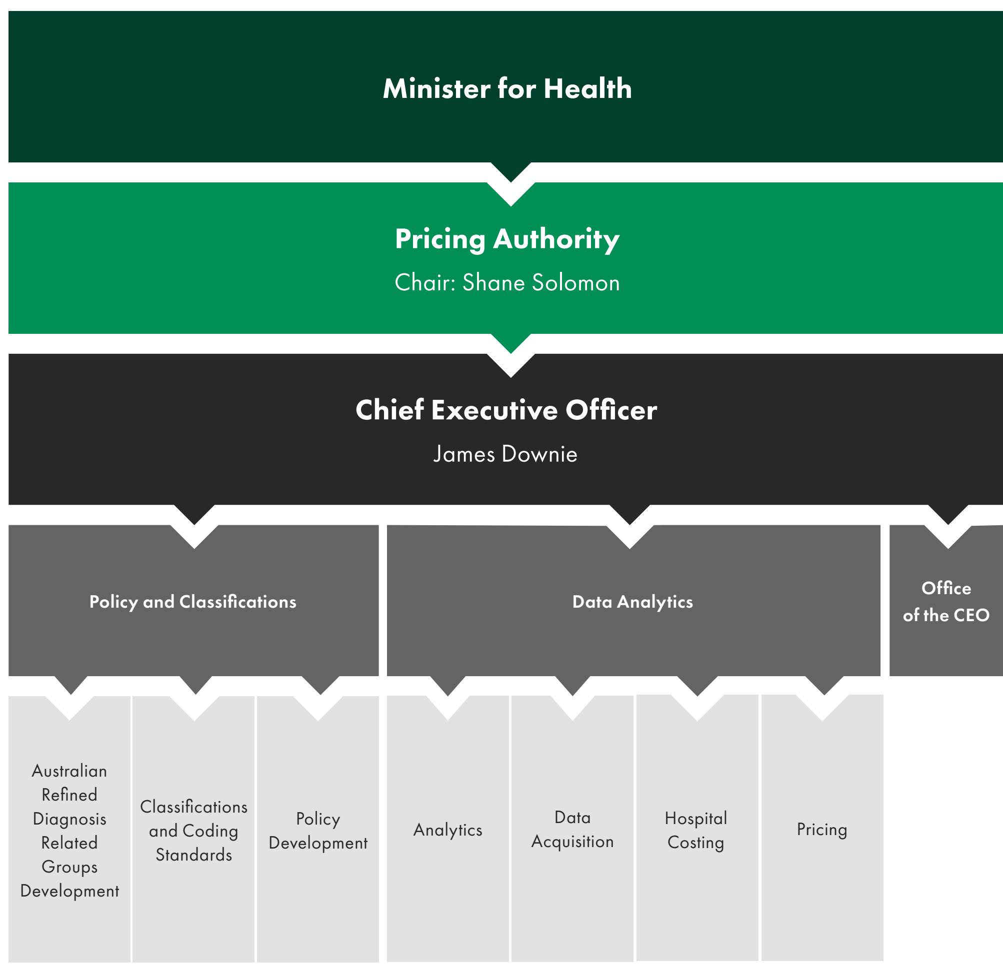
Funding = Volume x Price

Funding is provided by the National Health Funding Body to the Local Hospital Network



Organisational structure

Figure 1: IHPA's organisational structure as at 30 June 2018



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 information about the Pricing Authority, see p21.

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

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

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

Committees and working groups

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

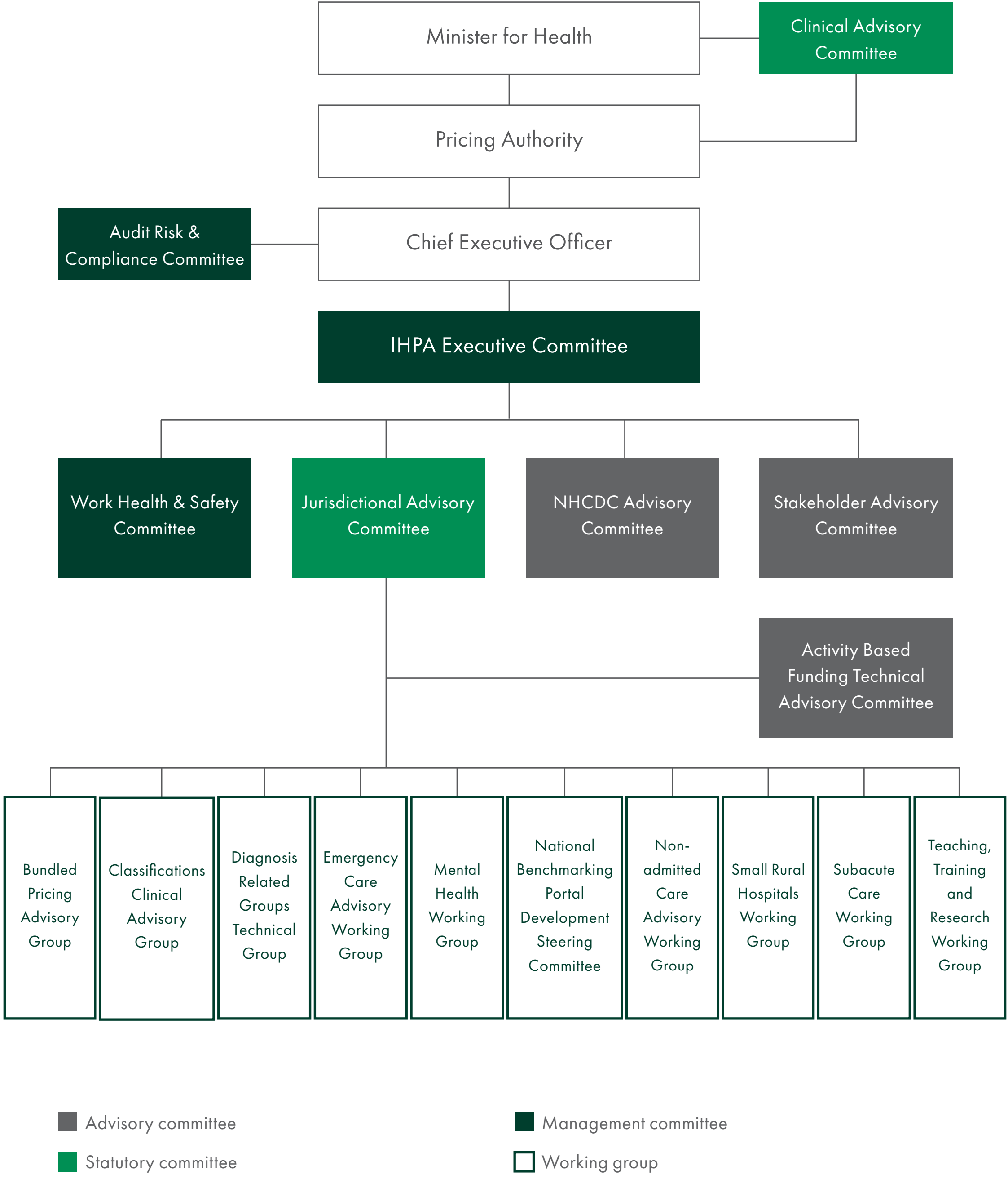
IHPA's statutory committees comprise the Clinical Advisory Committee and the Jurisdictional Advisory Committee, established under Parts 4.10 and 4.11 of the *National Health Reform Act 2011.*

Other advisory committees and working groups have been established to assist IHPA in the delivery of its Work Program, pursuant to Part 4.12 of the *National Health Reform Act 2011*, including:

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

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 was established under section 176 of the *National Health Reform Act 2011*. Its functions include advising the Pricing Authority on developing and specifying classification systems for health care and other services provided by public hospitals, the functions of the Pricing Authority, and matters referred to it by the Pricing Authority.

Committee members are appointed by the Australian Government Minister for Health. At 30 June 2018, the Clinical Advisory Committee consisted of 22 members.

The Clinical Advisory Committee is required to report annually. The Clinical Advisory Committee Annual Report, including details of its members and meetings, sits within the IHPA Annual Report, at p37.

Jurisdictional Advisory Committee

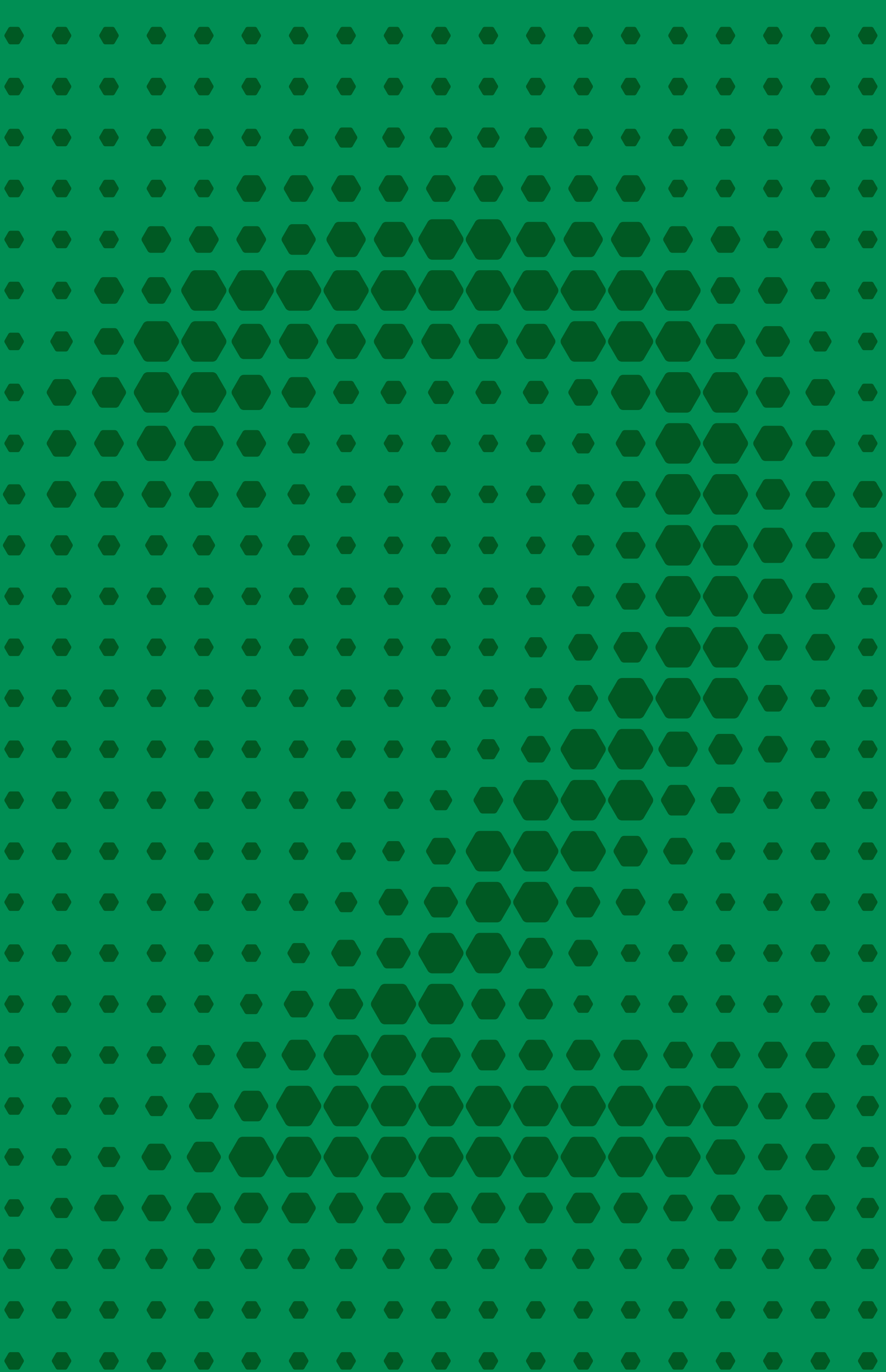
The Jurisdictional Advisory Committee was established under section 195 of the *National Health Reform Act 2011*. It consists of a Chair appointed by the Pricing Authority and nine other members (one to represent each state, territory and the Australian Government). Committee members are appointed by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

The Jurisdictional Advisory Committee met on 10 occasions between 1 July 2017 and 30 June 2018.

Jurisdictional Advisory Committee members as of 30 June 2018:

- James Downie, Chair
- Rob Anderson
- Helen Ceron
- Toni Cunningham
- Denise Ferrier
- Nigel Lyons
- Lynton Norris
- Ross Smith
- Jamin Woolcock

During the reporting period there were membership changes, with the Australian Capital Territory, Tasmania and Victoria advising IHPA of changes to Jurisdictional Advisory Committee membership by written instrument.



2 Pricing Authority

Chair's welcome

It is a privilege to chair the Pricing Authority and to present the Independent Hospital Pricing Authority's Annual Report for 2017–18.

A significant part of IHPA's program of work has been shaped by the commitments of the Addendum to National Health Reform Agreement, signed on 1 July 2017, to create financial incentives to further improve safety and quality in Australian public hospitals. The model proposed by IHPA has received broad support from jurisdictions.

As part of the safety and quality measures agreed by the Australian Government and state and territory governments, from 1 July 2017 no Commonwealth funding has been provided for episodes of care with sentinel events.

In 2017–18, IHPA developed a robust risk-adjusted approach to pricing for hospital acquired complications, which came into effect from 1 July 2018.

IHPA's work last year has also focussed on devising new approaches to help reduce avoidable hospital readmissions.

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

In the past 12 months, IHPA has made further significant contributions to advance safety and quality perspectives into public health funding.

The Pricing Authority was pleased to welcome three new members during the year. Ms Prudence Ford, Dr Kate Taylor and Ms Jennifer Williams bring a wealth of expertise and knowledge to the governing team, and their input and collaboration with the rest of the Pricing Authority has already been evident.

The achievements throughout 2017–18 would not be possible without the dedicated participation of our many stakeholders. I value the partnership we share with the Commonwealth Government and state and territory governments, as we continue to work together to improve efficiency and financial sustainability to deliver safe, high-quality health care for all Australians. I would also like to highlight the contributions made throughout the year by our Clinical Advisory Committee, whose advice is intrinsic to the decisions we make.

On behalf of the Pricing Authority, I thank James Downie, Chief Executive Officer for his insightful leadership and continued drive to improve public hospital financing in Australia. I also commend IHPA staff on their commitment to delivering a successful and complex program of work in a timely manner. Their outstanding achievements are described in detail throughout this report.

The Pricing Authority looks forward to contributing further to a sustainable, efficient and quality public health services for all Australians.

Shane Solomon
Chair, Pricing Authority
28 September 2018

Significant slowdown in costs

Cost per National Weighted Activity Unit (NWAU)

The NWAU is a measure of health service activity expressed as a common unit, against which the National Efficient Price is determined. Figure 3 indicates a significant reduction in the rate of growth in costs since 2011–12, to a sustained growth rate of 1.3 per cent.

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

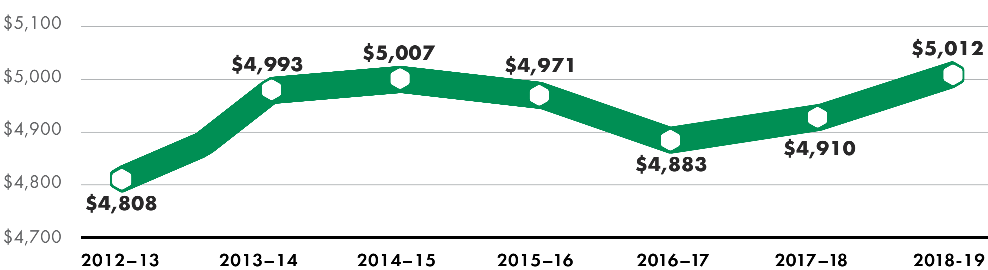
$5,100
$4,900
$4,700
$4,500
$4,300
$4,100
$3,900
$3,700
$3,500
$3,659
$3,804
$4,018
$4,307
$4,395
$4,544
$4,547
$4,605
$4,700
$4,779
$4,855
First National Efficient Price
was introduced
2006–2007 2007–2008 2008–2009 2009–2010 2010–2011 2011–2012 2012–2013 2013–2014 2014–2015 2015–2016 2016–2017

National Efficient Price

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

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

Figure 4: National Efficient Price 2012–2018



About the Pricing Authority

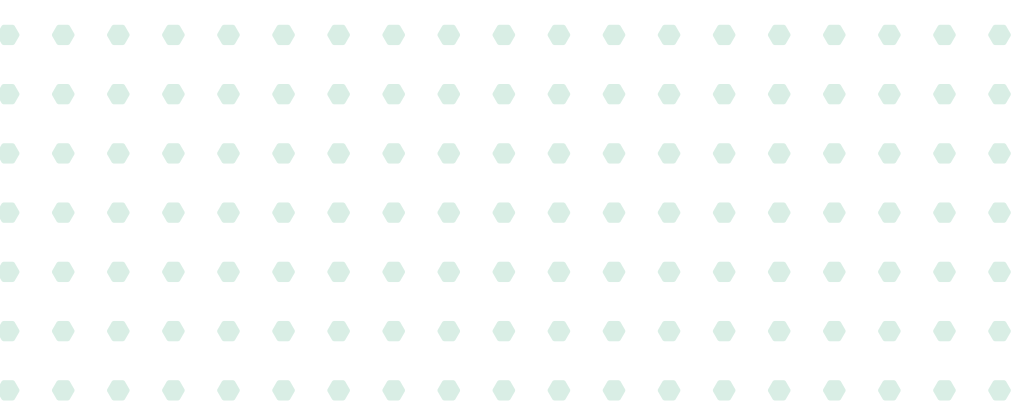
The Pricing Authority is responsible for promoting improved efficiency in and access to public hospital services. They do this by providing independent advice to government in relation to the efficient costs of services, and developing and implementing robust systems to promote Activity Based Funding for such services. The Pricing Authority consists of a Chair, a Deputy Chair and seven other members.

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

Members of the Pricing Authority bring significant and varied expertise to their role including substantial experience and knowledge of the health industry, healthcare needs, and the provision of health care in regional and rural areas. The Pricing Authority is supported by a Chief Executive Officer, who is responsible for the day-to-day running of IHPA.

Ms Prudence Ford, Dr Kate Taylor and Ms Jennifer Williams were appointed as members of the Pricing Authority with effect from 6 October 2017.

All Pricing Authority members are non-executive.



Members of the Pricing Authority — from left to right: Ms Prudence Ford, Dr Michael Walsh, Dr Kate Taylor, Mr Jim Birch (Deputy Chair), Mr Shane Solomon (Chair), Ms Jennifer Williams, A/Prof Bruce Chater, Mr Glenn Appleyard, Prof Jane Hall

Members of the Pricing Authority 2017–18

Mr Shane Solomon (Chair)

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

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

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

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

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

Mr Jim Birch (Deputy Chair)

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

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

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

Mr Glenn Appleyard

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

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

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

Associate Professor Bruce Chater

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

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

Ms Prudence Ford

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

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

She was also an independent consultant for several years, undertaking a range of reviews, inquiries and projects for both the government and non-government sectors. Prudence's experience encompasses policy development, program implementation, and delivery and corporate services.

Professor Jane Hall

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

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

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

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

Dr Kate Taylor

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

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

Dr Michael Walsh

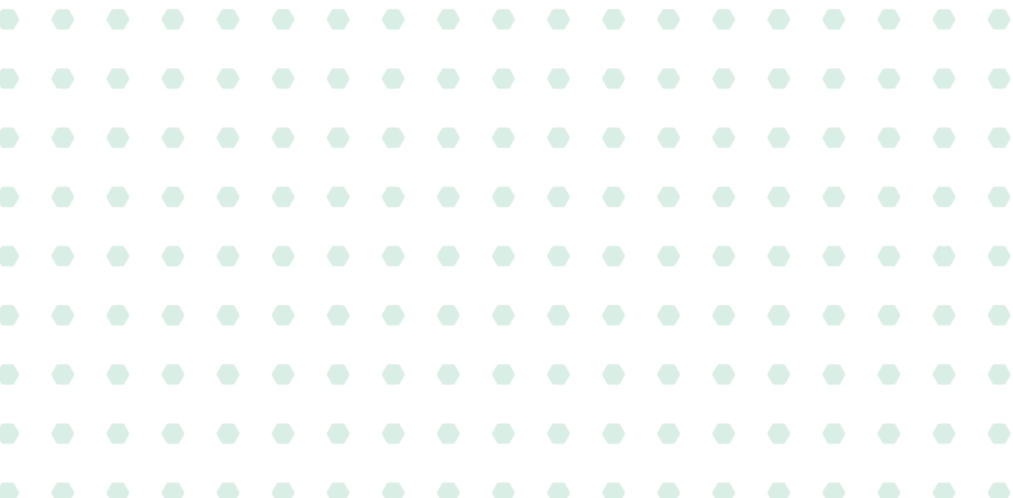
Dr Michael Walsh is Chief Executive of Cabrini Health, a private not-for-profit Catholic health service in Melbourne, Australia. He was recruited from Doha, Qatar, where he was Chief Executive of the National Health Authority. Prior to this, he worked in London, England as Chief Executive, South East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

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

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

Ms Jennifer Williams

Jennifer Williams holds a number of board positions, including Chair of Northern Health, Yooralla and Alfred Whole Time Medical Specialist Trust. She is also a member of the Australian Medical Research Advisory Board, and a Director of InfoXchange and Barwon Health. She has previously held the positions of Chief Executive of the Australian Red Cross Blood Service, Chief Executive of Alfred Health, and Chief Executive of Austin Health. She has also held senior management positions in the public and private sectors, including Director in the Victorian Department of Human Services.

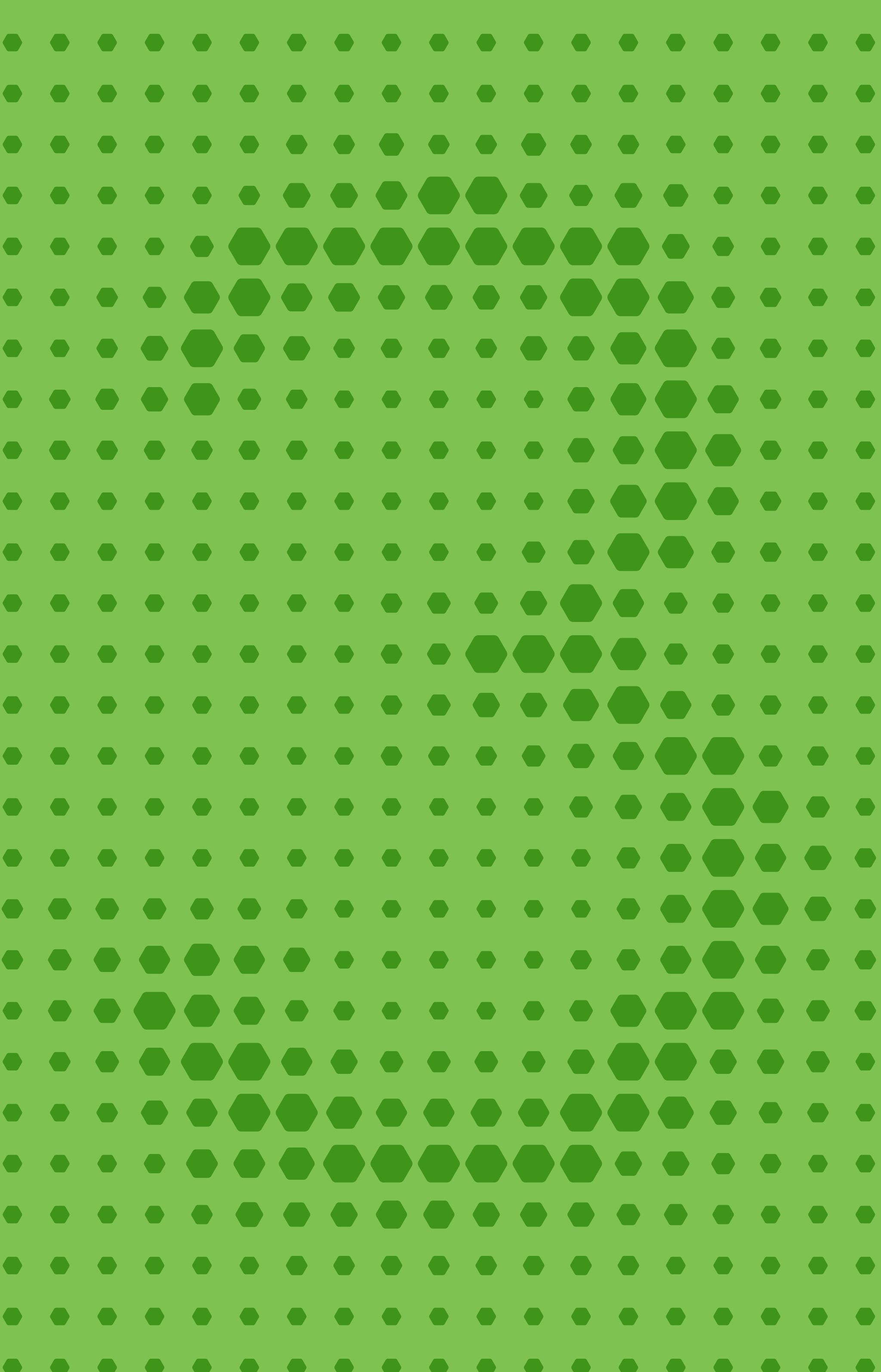


Meetings of the Pricing Authority 2017–18

The Pricing Authority met on 12 occasions between 1 July 2017 and 30 June 2018. The Chief Executive Officer, James Downie, as the Accountable Authority, attended all 12 meetings.

Table 1: Pricing Authority meetings and attendances 2017–18

Member	Meetings eligible	Meetings attended
Mr Shane Solomon (Chair)	12	12
Mr Jim Birch (Deputy Chair)	12	9
Mr Glenn Appleyard	12	10
A/Prof Bruce Chater	12	8
Ms Prudence Ford	9	8
Prof Jane Hall	12	10
Dr Kate Taylor	9	9
Dr Michael Walsh	12	9
Ms Jennifer Williams	9	9



3 IHPA 2017–18 overview

CEO's year in review

It is with great pleasure that I present IHPA's Annual Report 2017–18, and reflect on the agency's achievements over the past year.

It has been an honour to continue to provide support to the Pricing Authority throughout the year as they have continued to deliver on the requirements of the *National Health Reform Act 2011.*

IHPA was pleased to welcome three new members in 2017: Ms Prudence Ford, Dr Kate Taylor and Ms Jennifer Williams. We look forward to continuing to work with all members in 2018–19.

Last year IHPA completed the seventh round of its annual pricing function, publishing the Pricing Framework for Australian Public Hospital Services 2018–19. The Pricing Framework continues to provide a clear and stable methodology to guide our primary function: to determine the annual National Efficient Price and National Efficient Cost for public healthcare services.

We undertook detailed work to identify options for incorporating safety and quality into the pricing and funding of public hospital services. IHPA carried out this work in partnership with the Australian Commission on Safety and Quality in Health Care, and with advice from clinicians, jurisdictions, and other key stakeholders.

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

Work to develop and refine healthcare classification systems was another vital part of IHPA's program of work in 2017–18. Development of the first Australian Teaching and Training Classification and a new Emergency Care Services Classification made significant progress last year.

The Pricing Framework continues to provide a clear and stable methodology to guide our primary function.

Work continued to refine the Australian Mental Health Care Classification through specialist input, and to ensure it is clinically relevant and fit for purpose. We also began the process to develop the Australian Refined Diagnosis Related Groups Classification version 10.0, which was the first time IHPA has undertaken this work in-house.

Last year saw the release of the Australian Hospital Patient Costing Standards version 4.0, which facilitates the collection of cost data from public and private hospitals, used to refine classification systems, set prices and inform policy. This publication was presented in an interactive, digital format to improve the usability and applicability of the Australian Hospital Patient Costing Standards.

The results achieved in relation to each of the program objectives outlined in the Corporate Plan are reported in this annual report, including information on IHPA's management and accountability, and financial results.

I would like to express my gratitude to the Clinical Advisory Committee for their expert guidance throughout the year.

I acknowledge and would like to thank Australian governments, stakeholder groups, and clinical and consumer advisors for the significant input and valuable advice extended to IHPA to address the emerging challenges in public health services.

Once again, I commend the dedication, integrity and professionalism of IHPA staff, who enable the agency to deliver on its extensive work program effectively.

Their work to deliver the requirements of the Addendum to the National Health Reform Agreement under tight time frames has required a significant commitment and teamwork across the organisation.

James Downie
Chief Executive Officer, IHPA
28 September 2018

2017–18 snapshot

Some of the key achievements from IHPA's Work Program for 2017-18 include:

July

Australian Modification of the International Statistical Classification of Diseases 10th edition implemented

August

Consultation on the Australian Teaching and Training Classification

October

Activity Based Funding Conference and the 33rd Patient Classification Systems International Conference 2017

November

Pricing Framework for Australian Public Hospital Services 2018–19 published

December

Consultation on the new Australian Emergency Care Classification

February

Australian Hospital Patient Costing Standards version 4.0 released

Consultation on the new Australian Non-Admitted Care Classification

National Hospital Cost Data Collection, Private Hospital Cost Report, Round 20 (Financial year 2015-16) published

March

National Hospital Cost Data Collection, Round 20 Cost Report published

National Efficient Price and National Efficient Cost Determinations for 2018–19 published

May

Consultation on IHPA's draft Work Program 2018–19

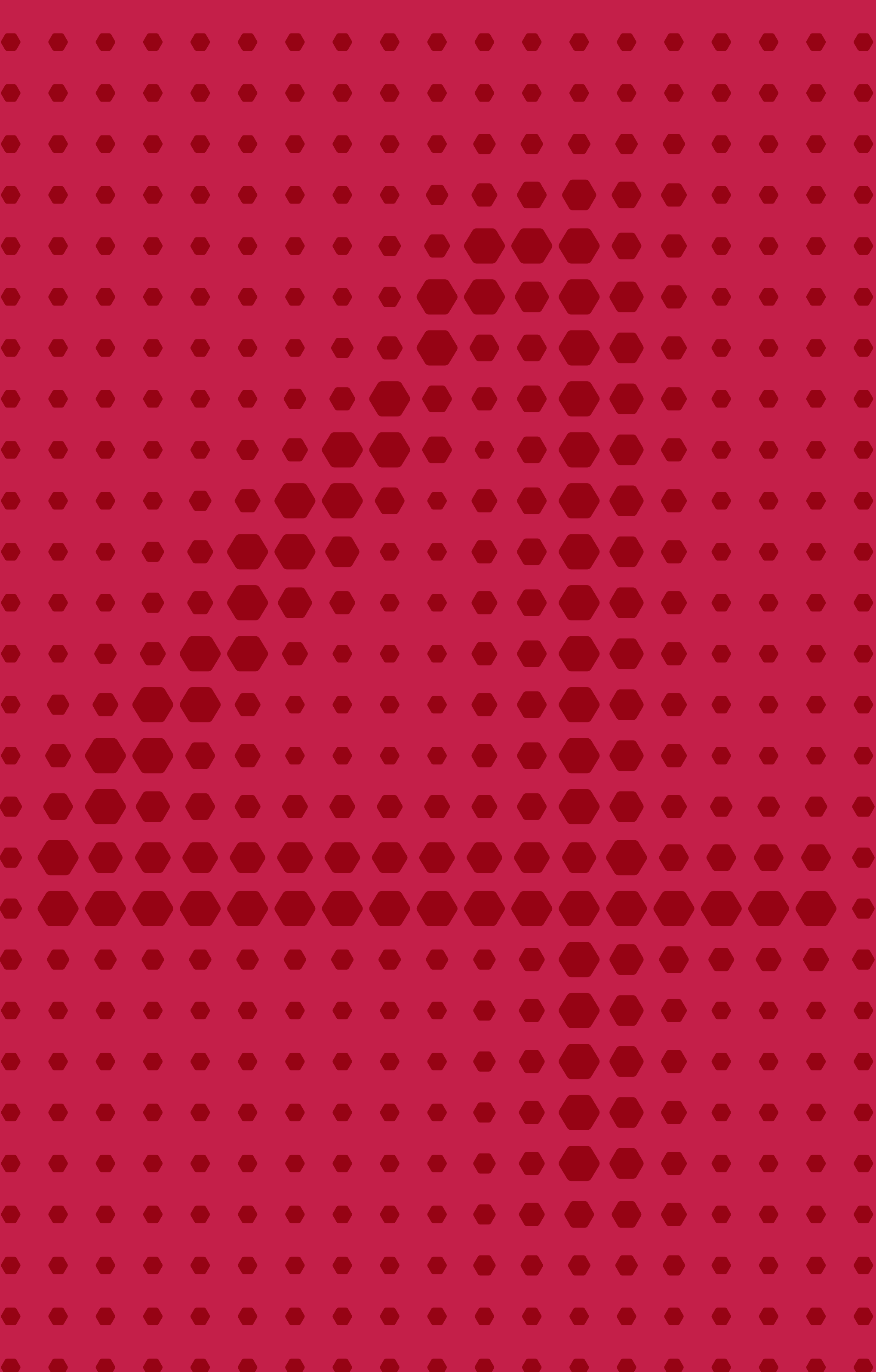
Consultation on the Australian Refined Diagnosis Related Groups version 10.0

June

Consultation on the Pricing Framework for Australian Public Hospital Services 2019–20

Three Year Data Plan 2018–19 to 2020–21 published

Publication of IHPA Work Program 2018–19



4 Clinical Advisory Committee

Annual Report

Letter from the Chair

It is a privilege to chair the Clinical Advisory Committee and to present the committee's Annual Report for 2017–18.

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

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

In 2017–18, the committee continued to provide input into the Pricing Framework for Australian Public Hospital Services 2018–19, ensuring the policies outlined in it are clinically relevant and meet the needs of the clinical workforce. The committee provided advice and analysis to deliver clinically relevant National Efficient Price and National Efficient Cost Determinations for 2018–19.

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

The Clinical Advisory Committee also provided significant input into the development of national classification systems for emergency care, teaching and training, and mental health care. It provided substantial clinical advice before the Australian Refined Diagnosis Related Groups version 10.0 was open for public consultation.

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

On behalf of the Clinical Advisory Committee, I acknowledge and commend the Pricing Authority, and the IHPA Chief Executive Officer and staff for delivering a successful program of work in 2017–18.

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

Associate Professor
Alasdair MacDonald
Chair, Clinical Advisory Committee
28 September 2018

About the Clinical Advisory Committee

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

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

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

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

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

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

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

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

Membership

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

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

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

Table 2: Membership and meetings of the Clinical Advisory Committee in 2017–18

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

[1] Prof Graham J Reynolds resigned from Clinical Advisory Committee effective 3 May 2018.

Clinical Advisory Committee meetings 2017–18

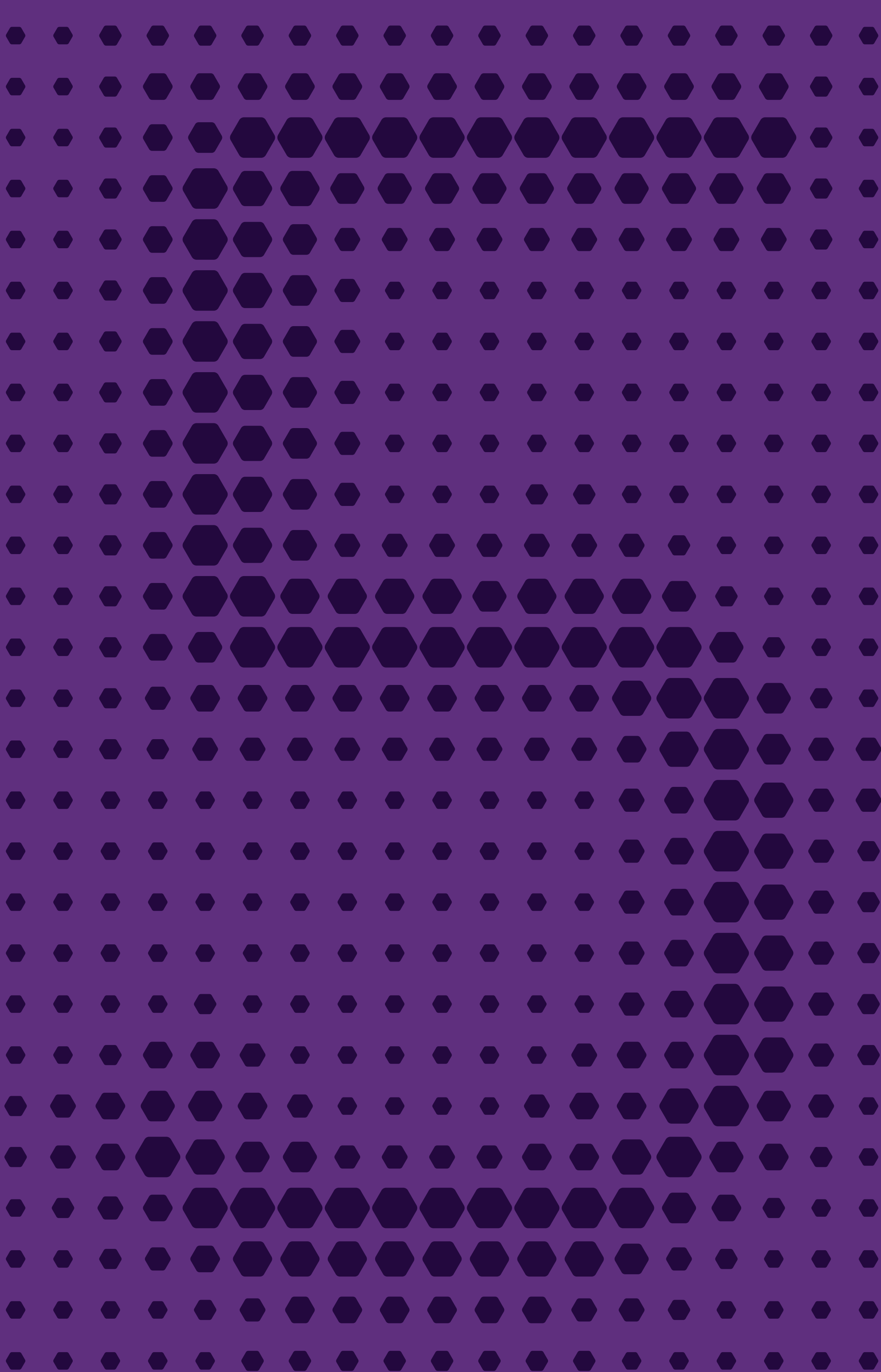
The meeting dates during the period in review were as follows:

4 September 2017
13 November 2017
14 May 2018

2017–18 snapshot

In 2017–18, the Clinical Advisory Committee supported IHPA's Work Program to deliver the following key achievements:

- The Pricing Framework for Australian Public Hospital Services 2018–19
- IHPA's determination of the National Efficient Price and National Efficient Cost for 2018–19
- Development of a new classification system for teaching and training
- Work to develop a new classification system for emergency care services
- Work to develop version 10.0 of the Australian Refined Diagnosis Related Groups classification.



5 Management and accountability

Key corporate governance practices

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

The Pricing Authority delivers the functions defined in the *National Health Reform Act 2011*. The Pricing Authority approves IHPA's core business activities — Activity Based Funding 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 identified with reference to current business and environmental issues facing IHPA. At 30 June 2018, there were eight strategic risks under active management.

These risks were:

- data and information governance
- external scrutiny
- maintenance of independence
- human capital management
- information and communications technology
- compliance
- stakeholder engagement
- procurement 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 risks, as it enables them to be 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* 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 receives management assurances on IHPA's compliance obligations through an organised system of controls and special exercises, including substantive testing, monthly reports, exception notifications, and compliance audits undertaken by an independent internal auditor.

Compliance achievements during the year include:

- information and communications technology systems assessed as compliant with the top risks defined by Australian Signals Directorate
- no compliance issues arising from IHPA's administration of relevant sections of the *National Health Reform Act 2011*
- no material compliance issues emanating from the *Public Governance Performance and Accountability Act 2013*.

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 are approved by the Chief Executive Officer, the Accountable Authority.

Audit, Risk and Compliance Committee

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

At 30 June 2018, members of the Audit, Risk and Compliance 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 2017–18 financial year, IHPA received shared services resourcing from the Department of Health.

The Department of Health charged IHPA $379,000 to provide these services covering treasury, processing of financial transactions, information and communication desktop services, and parliamentary support.

Ecologically sustainable development and environmental performance

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

Management of human resources

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

Table 3: Staff numbers by classification, gender and full-time/part-time status at 30 June 2018

	FEMALE			MALE			
Classification	**Total**	**F/T**	**P/T**	**Total**	**F/T**	**P/T**	**Total**
HOPO	0	0	0	1	1	0	1
SES	2	2	0	0	0	0	2
EL2	5	5	0	5	5	0	10
EL1	9	5	4	8	8	0	17
APS Level 6	6	5	1	4	4	0	10
APS Level 5	2	2	0	0	0	0	2
TOTAL	**24**	**19**	**5**	**18**	**18**	**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 2017–18, IHPA's training investment averaged $3,530 per staff member.

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 Chief Executive Officer enhanced his skills through attendance at domestic and international Activity Based Funding events, and attended specialised leadership training that was also made available to IHPA mid-level and senior management staff. The Chief Executive Officer receives regular performance feedback via the Pricing Authority meetings.

Work, health and safety

In 2017–18, 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 work, health and safety matters.

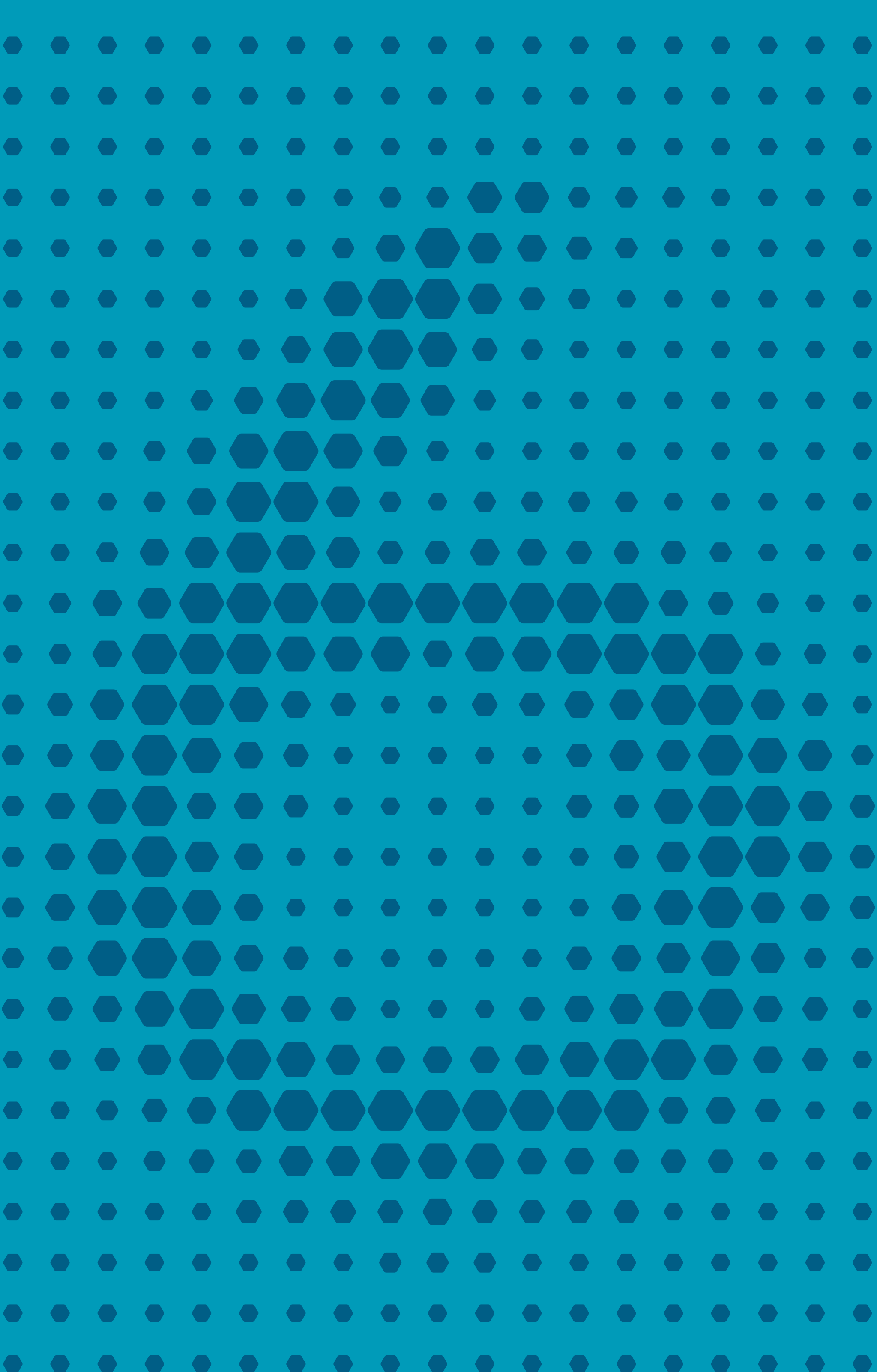
IHPA maintained its ongoing practice of providing workplace assessments for new staff, and as required.

In 2017–18 no notifiable incidents were identified in regards to work, health and safety. 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 2017–18, IHPA commissioned the following advertising that must be reported under s. 311A of the *Commonwealth Electoral Act 1918*.

- Consultation paper on the Pricing Framework for Australian Public Hospital Services 2018–19 — dentsu x Australia — $20,816.43.



6 Annual performance statements

Introductory statement

I, James Downie, as the Accountable Authority of the Independent Hospital Pricing Authority (IHPA), present the 2017–18 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. IHPA does this by developing and implementing robust systems to support Activity Based Funding for these 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 Determination and the National Efficient Cost Determination each year. The Pricing Framework for Australian Public Hospital Services outlines the principles, scope and methodology to be adopted by IHPA in the setting of the National Efficient Price and National Efficient Cost for public hospital services in the next financial year. The Pricing Framework forms the policy basis for the determinations.

During 2017–18, IHPA undertook further technical development to improve the price-setting process and continue to refine the models used to determine the National Efficient Price and National Efficient Cost.

Criteria

1. Publish the Pricing Framework for Australian Public Hospital Services 2018–19 by 31 December 2017.
2. Publish the National Efficient Price and National Efficient Cost Determinations by 31 March 2018.
3. Reduction in the range between the 50th and 90th percentile cost per National Weighted Activity Unit when compared to 2014–15 data.

Source

- 2017–18 Corporate Plan — Strategy 1
- 2017–18 Portfolio Budget Statement Program 1.1

Results against performance criteria

1. The Pricing Framework for Australian Public Hospital Services 2018–19 was published on 27 November 2017.
2. The National Efficient Price and National Efficient Cost Determinations were published on 5 March 2018.
3. The 50th percentile of cost per National Weighted Activity Unit remained stable at $4,636 in 2015–16. The 90th percentile decreased from $5,940 in 2014–15 to $5,772 in 2015–16, representing a reduction in the range between the 50th and 90th percentile of $170.

Activity 2: Develop national classifications for Activity Based Funding

Activity Based Funding requires robust classification systems on which pricing can be based. Classifications aim to provide the healthcare sector with a nationally consistent method of classifying all types of patients, their treatment, and associated costs. IHPA has already determined the national 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 2017–18, IHPA finalised the first version of the Australian Teaching and Training Classification and completed the development process for the first version of the Australian Emergency Care Classification for approval later in 2018. IHPA continued work to further develop the classifications for admitted acute care, subacute care, non-admitted patient care and mental health care.

Criteria

1. Continue the refinement of the Australian Mental Health Care Classification version 1.0, specifically the refinement of the first level of the classification — the mental health phase of care.
2. Complete new classification for teaching and training.
3. Develop a new classification system for emergency care services.
4. Continue development of the subacute care classification using reported data and clinical advice.
5. Continue development work on the new classification for non-admitted care by preparing for a nationwide costing study.
6. Continue development work on the Eleventh Edition of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification, Australian Classification of Health Interventions, Australian Coding Standards; collectively known as ICD-10-AM/ACHI/ACS, for implementation from 1 July 2019. Continue development work on the Australian Refined Diagnosis Related Groups version 10.0 for release before 30 June 2019.
7. Provide a further increase in the proportion of funding for public services using Activity Based Funding as reported by the Administrator of the National Health Funding Pool.

Source

- 2017–18 Portfolio Budget Statement Program 1.1

Result against performance criteria

1. In 2017–18, IHPA continued the refinement of the Australian Mental Health Care Classification version 1.0. The inter-rater reliability study, conducted on the concept of mental health phase of care was completed successfully in 2017. As a result, IHPA is undertaking further investigation to clinically review and refine the phase of care in the Australian Mental Health Care Classification to improve the classification and support data reporting.

2. IHPA finalised the Australian Teaching and Training Classification version 1.0 using the data from the teaching, training and research costing study, and targeted consultation with key stakeholders. The data specifications that support this classification will continue to be reviewed to further refine the classification in the future.
3. The development of the new Australian Emergency Care Classification continued in 2017–18. Analysis of the emergency care costing study data as well as feedback from the public consultation enabled the classification to place greater emphasis on patient factors such as diagnosis and complexity.
4. IHPA has begun a review of the Australian National Subacute and Non-Acute Patient version 4 classification with a view to developing version 5.0, by analysing the most recent costing and activity data relating to rehabilitation, palliative care, geriatric evaluation and management, psychogeriatric and non-acute care. Clinical and jurisdictional advice is being provided through the IHPA Subacute Care Working Group to inform the analytical findings to support the refinement process.
5. Work on the development of the Australian Non-Admitted Care Classification continues. A stakeholder consultation paper was released in early 2018, and submissions received will inform the ongoing development of the classification. As part of the strategic plan going forward, a national costing study will be undertaken, commencing in early 2019 to inform the development process. A shortlist of diagnoses and interventions that represent non-admitted services will be developed to test during the costing study.
6. Refinement of the classifications for acute admitted care continued with the development of the Eleventh Edition of ICD-10-AM/ACHI/ACS, which is due for implementation from 1 July 2019. Version 10.0 of the Australian Refined Diagnosis Related Groups classification will be finalised during 2018–19, and will be used for pricing admitted acute episodes of care from 1 July 2020. Refinements are being undertaken following clinical and statistical analysis and consultation with clinicians, jurisdictions and other stakeholders to ensure that the classifications remain current, clinically relevant, and adequately explain the costs of providing admitted acute hospital care.
7. As of May 2018, 83.23 per cent of funding for public services paid by the Administrator of the National Health Funding Pool was based on Activity Based Funding. This is an increase of less than one per cent from 2013–14.

Table 4: Proportion of funding for public hospital services using Activity Based Funding

Year	per cent
2013–14	82.43%
2014–15	83.08%
2015–16	85.42%
2016–17	83.95%
2017–May 2018	83.23%

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 National Efficient Price of those services. IHPA has developed a rolling Three Year Data Plan to communicate to the Australian Government and states and territories the data requirements, data standards and timelines that IHPA will use to collect data over the coming three years. To ensure greater transparency, IHPA publishes data compliance reports 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 2017.
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

- 2017–18 Corporate Plan — Strategy 4
- 2017–18 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 2017.
2. The biannual data compliance reports were developed in consultation with jurisdictions, and published on the IHPA website.
3. Activity Based Funding data submissions were assessed based on the published data standards such as data set specifications and data request specifications. The IHPA Data Compliance Policy was used to assess jurisdictional compliance ratings.
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. A Statement of Assurance, which provides detailed information about data quality and limitation, accompanies final data submission.

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 the request.

Source

- 2017–18 Portfolio Budget Statement Program 1.1

Result against performance criteria

1. An updated Cost-Shifting and Cross-Border and Dispute Resolution Framework (version 3.2) was published in June 2018.
2. In 2017–18 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.

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

Criteria

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

Source

- 2017–18 Corporate Plan
- 2017–18 Work Program

Results against performance criteria

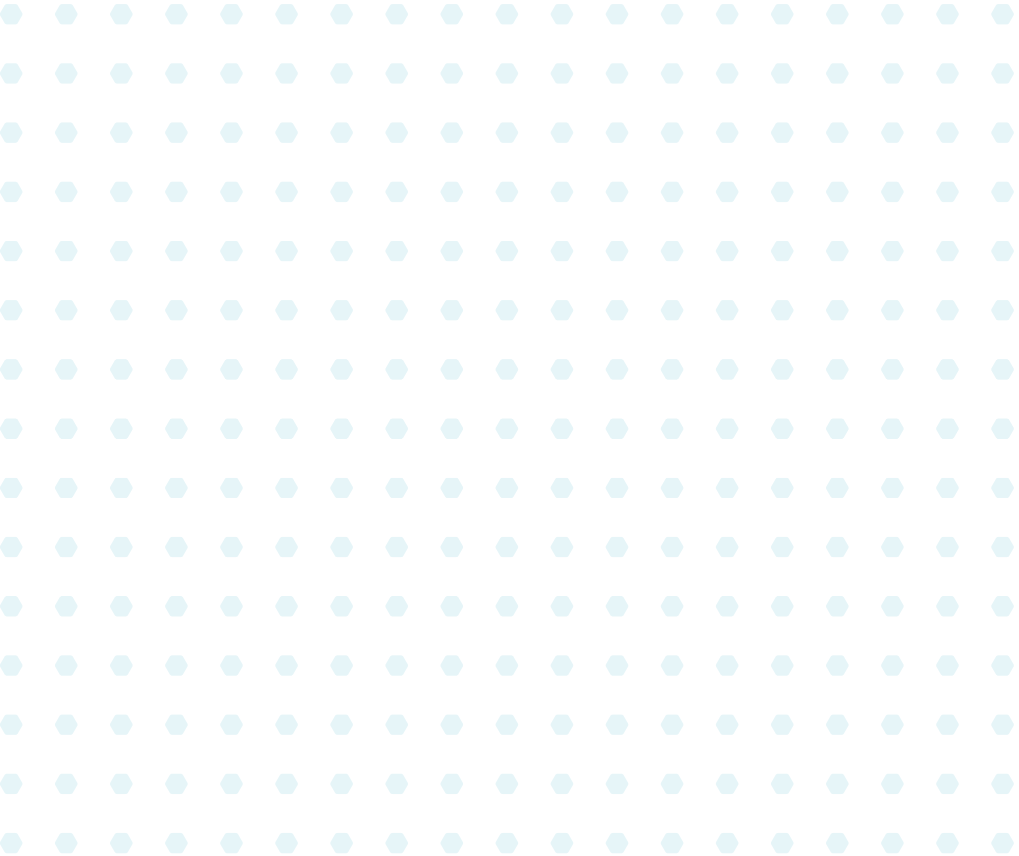
1. In 2017–18 IHPA maintained up to 17 committees and working groups to provide expert advice and to ensure the transparency and integrity of the organisation. During the reporting period, IHPA held 68 meetings with the various committees and working groups.
2. IHPA conducted six public consultation processes in 2017–18, each in accordance with the *National Health Reform Act 2011*. These included:
    i. Pricing Framework for Australian Public Hospital Services 2018–19 (July 2017)
    ii. Development of the Australian Teaching and Training Classification (August 2017)
    iii. Development of the Australian Emergency Care Classification (November 2017)
    iv. IHPA Work Program (May 2018)
    v. Development of the Australian Non-Admitted Care Classification (February 2018)
    vi. Development of the Australian Refined Diagnosis Related Groups version 10.0 Classification System, and ICD-10-AM/ACHI/ACS Tenth Edition (June 2018).

3. All submissions received by IHPA were presented to the Pricing Authority for consideration and published on the IHPA website.
4. IHPA received 75 inbox enquiries during the reporting period. 91 per cent were responded to within two weeks, and 39 percent of those were responded to on the day of receipt.

Table 5: Response rate to enquiries 1 July 2017 – 30 June 2018

Total Requests	Same day response	1–7 days	7–14 days	15+ days
75	29	28	11	7

5. IHPA hosted its Activity Based Funding Conference 2017 in partnership with Patient Classification Systems International 33rd International Conference from 9–13 October. This conference attracted 426 delegates from around the world.



Analysis

IHPA has had another productive year, meeting its performance criteria as well as deliverables in the IHPA Work Program 2017–18.

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 2017–18 provides a more detailed set of goals and deliverables than those included in the Portfolio Budget Statements and IHPA's Corporate Plan. It is developed each year through a consultative process with government and health sector stakeholders, and is published on the IHPA website (see www.ihpa.gov.au/publications).

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.

IHPA's National Benchmarking Portal continued to enable staff throughout the public hospital system to compare hospital-level cost and activity data across the country.

The portal provides an important way to recognise the critical role that data plays in IHPA's work, and is a key driver in safety and quality measures going forward. IHPA has undertaken a consultation process which sought ways to broaden access to its data for universities and researchers.

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 p20).

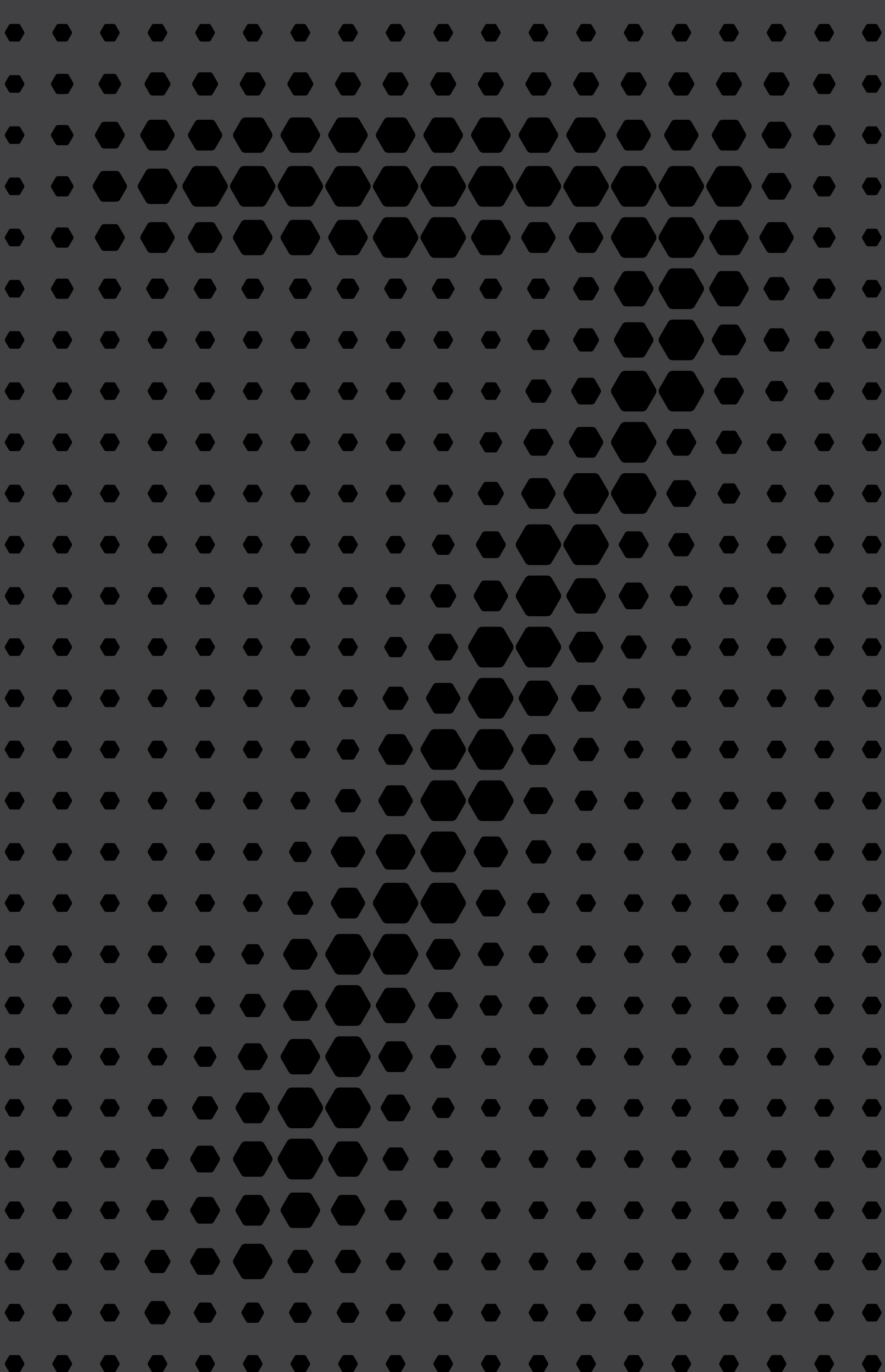
During the financial year 2017–18, IHPA undertook work to develop and evaluate options for introducing safety and quality into pricing and funding models for Australian public hospitals. The approach to the implementation of pricing and funding for safety and quality has been rolled out on a staged basis.

Since 1 July 2017, no Commonwealth Government funding has been provided for any public hospital episode that includes a sentinel event, such as surgical procedures involving the wrong body part or medication errors leading to death.

The National Efficient Price for 2018–19 introduced a new funding model, based on a risk-adjusted methodology that reduces 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.

In June 2018 IHPA conducted a public consultation on a funding approach to reduce avoidable hospital readmissions in its Pricing Framework for Australian Public Hospital Services 2019–20.

IHPA will continue to drive internal process improvements, with a focus on refining funding models, learning and development, and data use and analysis. Along with exploring opportunities for the new long-term, system-wide reforms focusing on value and outcome-based health, IHPA will continue to improve on providing safety and quality, efficiency, and transparency in public health systems.



7 Financial management

ANAO report

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Independent Hospital Pricing Authority for the year ended 30 June 2018:

(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 2018 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 2018 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* (the Code) to the extent that they are not in conflict with the *Auditor-General Act 1997*. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the 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, as applicable, matters related to going concern and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

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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

Sean Benfield
Executive Director
Delegate of the Auditor-General

Canberra
17 September 2018

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Independent Hospital Pricing Authority Financial Statements 2017–18

For the year ended 30 June 2018

Statement by the Chief Executive Officer and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2018 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

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

James Downie
Chief Executive Officer
14 September 2018

Chris Miljak
Chief Financial Officer
14 September 2018

Statement of comprehensive income

for the period ended 30 June 2018

	Notes	**2018 $'000**	2017 $'000	Original Budget $'000
NET COST OF SERVICES				
Expenses				
Employee benefits	1.1A	**6,250**	5,728	6,201
Suppliers	1.1B	**11,353**	11,015	16,315
Depreciation and amortisation	2.2A	**348**	533	717
Finance costs	1.1C	**-**	21	-
Write-down and impairment of assets	1.1D	**-**	74	-
Total expenses		**17,951**	17,371	23,233
OWN-SOURCE INCOME				
Own-source revenue				
Sale of goods and rendering of services	1.2A	**1,268**	909	850
Interest		**208**	125	96
Resources received free of charge	1.2B	**5,861**	5,481	6,811
Total own-source revenue		**7,337**	6,515	7,757
Gains				
Other gains	1.2C	**186**	4	-
Total gains		**186**	4	-
Total own-source income		**7,523**	6,519	7,757
Net cost of services		**(10,428)**	(10,852)	(15,476)
Revenue from Government	1.2D	**14,476**	13,538	15,476
Surplus		**4,048**	2,686	-
Other comprehensive income				
Changes in asset revaluation surplus		**-**	72	-
Total comprehensive surplus		**4,048**	2,758	-

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

Budget Variances Commentary

Statement of Comprehensive Income

Total expenses of $17.951m were lower than the budgeted amount of $23.233m. The main driver of the underspend were supplier expenses which were lower than budget due to a rephasing of activities into the 2018–19 year. Total own source income of $7.523m was under budget primarily due to lower resources received free of charge (driven by lower than expected staffing levels) partially offset by higher sales of goods and services, interest and other gains.

Statement of financial position

as at 30 June 2018

	Notes	**2018 $'000**	2017 $'000	Original Budget $'000
ASSETS				
Financial assets				
Cash and cash equivalents	2.1A	**13,712**	9,793	6,633
Trade and other receivables	2.1B	**80**	211	339
Total financial assets		**13,792**	10,004	6,972
Non-financial assets				
Buildings	2.2A	**292**	201	383
Plant and equipment	2.2A	**276**	342	314
Computer software	2.2A	**2**	2	-
Internally developed software	2.2A	**553**	732	-
Other intangibles	2.2A	**77**	115	247
Other — prepayments		**153**	254	49
Total non-financial assets		**1,353**	1,646	993
Total assets		**15,145**	11,650	7,965
LIABILITIES				
Payables				
Suppliers	2.3A	**2,174**	2,543	1,384
Other payables	2.3B	**7**	109	355
Total payables		**2,181**	2,652	1,739
Provisions				
Employee provisions	4.1A	**76**	123	130
Other provisions	2.4	**151**	186	165
Total provisions		**227**	309	295
Total liabilities		**2,408**	2,961	2,034
Net assets		**12,737**	8,689	5,931
EQUITY				
Contributed equity		**400**	400	400
Reserves		**88**	88	16
Retained surplus		**12,249**	8,201	5,515
Total equity		**12,737**	8,689	5,931

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

Budget Variances Commentary

Statement of Financial Position

Total assets of $15.145m were higher than the budget of $7.965m principally due to a higher cash balance as a result of the prior and current year surplus.

Total liabilities of $2.408m were higher than budget primarily due to higher supplier payables.

Total equity of $12.737m was higher than the budget of $5.931m due to the prior and current period surplus, noting that the budget is derived on a break-even assumption.

Statement of changes in equity

for the period ended 30 June 2018

	Notes	**2018 $'000**	2017 $'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		**8,201**	23,691	23,691
Transaction with owners				
Reduction in receivable from Government		**-**	(18,176)	(18,176)
Comprehensive income				
Surplus for the period		**4,048**	2,686	-
Closing balance as at 30 June		**12,249**	8,201	5,515
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		**88**	16	16
Comprehensive income				
Other comprehensive income		**-**	72	-
Closing balance as at 30 June		**88**	88	16
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		**8,689**	24,107	24,107
Transaction with owners				
Reduction in receivable from Government		**-**	(18,176)	(18,176)
Comprehensive income				
Surplus for the period		**4,048**	2,686	-
Other comprehensive income		**-**	72	-
Closing balance as at 30 June		**12,737**	8,689	5,931

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

Budget Variances Commentary

Statement of Changes in Equity

Total equity of $12.737m was higher than the budget $5.931m due to the prior and current period surplus, noting the budget is derived on a break-even assumption.

Cash flow statement

for the period ended 30 June 2018

	Notes	2018 $'000	2017 $'000	Original Budget $'000
OPERATING ACTIVITIES				
Cash received				
Receipts from Government		**14,476**	13,538	15,460
Sale of goods and rendering of services		**1,459**	897	866
Interest		**208**	125	96
Net GST received		**1,044**	1,222	1,303
Other		**-**	62	-
Total cash received		**17,187**	15,844	17,725
Cash used				
Employees		**442**	1,283	6,197
Suppliers		**12,821**	12,351	10,682
Net GST paid		**-**	-	85
Total cash used		**13,263**	13,635	16,964
Net cash from operating activities	3.1	**3,924**	2,209	761
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment		**5**	39	865
Purchase of internally developed software		**-**	777	-
Total cash used		**5**	816	865
Net cash used by investing activities		**(5)**	(816)	(865)
Net increase in cash held		**3,919**	1,393	(104)
Cash and cash equivalents at the beginning of the reporting period		**9,793**	8,400	6,737
Cash and cash equivalents at the end of the reporting period	2.1A	**13,712**	9,793	6,633

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 2018 of $13.712m was higher than the budgeted amount of $6.663m primarily due to the prior and current period surplus, noting the budget is derived on a break-even assumption.

Overview

Objectives of the Independent Hospital Pricing Authority

The Independent Hospital Pricing Authority (IHPA) is an Australian Government controlled, not-for-profit entity. It 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 programs, is dependent on Government policy and on continuing funding by Parliament for the entity's administration and programs.

The basis of preparation

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

The financial statements have been prepared in accordance with the:

a. Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR) for reporting periods ending on or after 1 July 2017; 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 2017–18

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

New Australian Accounting Standards

Adoption of new Australian Accounting Standard requirements

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

Future Accounting Standard requirements

The following new, revised and amending standards 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 IHPA 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 IHPA's financial statements.

Significant accounting judgements and estimates

Except where specifically identified and disclosed, IHPA has determined that no accounting assumptions and estimates have a significant risk of causing a material adjustment to carrying amounts of asets 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 financial year ended 30 June 2018.

Note 1.1 Expenses

	2018 $'000	2017 $'000
NOTE 1.1A: EMPLOYEE BENEFITS		
Wages and salaries	**508**	526
Superannuation		
Defined contribution plans	**67**	71
Leave and other entitlements	**254**	123
Wages and salaries for staff provided by Department of Health	**5,421**	5,008
Total employee benefits	**6,250**	5,728

Accounting Policy

Employee benefits

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

	2018 $'000	2017 $'000
NOTE 1.1B: SUPPLIERS		
Goods and services supplied or rendered		
Consultants	**4,312**	3,443
Contractors	**3,929**	5,093
Travel	**294**	250
Training	**141**	114
IT services	**548**	668
Publishing materials	**267**	377
Legal expenses and audit fees	**226**	248
Conferences and seminars	**763**	9
Other	**343**	338
Total goods and services supplied or rendered	**10,823**	10,540
Goods supplied	**337**	458
Services rendered	**10,486**	10,082
Total goods and services supplied or rendered	**10,823**	10,540

Continued

	2018 $'000	2017 $'000
Other suppliers		
Operating lease rentals in connection with minimum lease payments	**528**	469
Workers compensation expenses	**2**	6
Total other suppliers	**530**	475
Total suppliers	**11,353**	11,015

Leasing commitments

On 1 June 2018, IHPA in its capacity as lessee entered into a lease for office accommodation for the period up to 31 May 2023. The lease is subject to an annual cost increase and is not able to be cancelled.

Accounting Policy

Lease incentives

Lease incentives have been taken as rent abatement spread across the term of the lease in equal monthly deductions.

Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:	2018 $'000	2017 $'000
Within 1 year	**760**	605
Between 1 to 5 years	**2,985**	-
Total operating lease commitments	**3,745**	605
NOTE 1.1C: FINANCE COSTS		
Unwinding of discount	-	21
Total finance costs	**-**	21

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 2018. 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

	2018 $'000	2017 $'000
OWN-SOURCE REVENUE		
NOTE 1.2A: SALE OF GOODS AND RENDERING OF SERVICES		
Sale of goods	**814**	909
Rendering of services	**454**	-
Total sale of goods and rendering of services	**1,268**	909

Accounting Policy

Sale of goods and rendering of services

Revenue from the sale of goods is recognised when:

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

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

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

a. amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and

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

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

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

	2018 $'000	2017 $'000
NOTE 1.2B: RESOURCES RECEIVED FREE OF CHARGE		
Departmental contribution received free of charge	**5,799**	5,423
Other resources received free of charge	**62**	58
Total other revenue	**5,861**	5,481

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 revenue.

	2018 $'000	2017 $'000
NOTE 1.2C: OTHER GAINS		
Cost recovery	**-**	4
Reversal of restoration provision	**186**	-
Total other gains	**186**	4

Refer to note 2.4 Other provisions for restoration provison details.

	2018 $'000	2017 $'000
NOTE 1.2D: REVENUE FROM GOVERNMENT		
Amounts from Department of Health	**14,476**	13,538
Total revenue from Government	**14,476**	13,538

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 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

	2018 $'000	2017 $'000
NOTE 2.1A: CASH AND CASH EQUIVALENTS		
Cash on hand or on deposit	**13,712**	9,793
Total cash and cash equivalents	**13,712**	9,793

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.

	2018 $'000	2017 $'000
NOTE 2.1B: TRADE AND OTHER RECEIVABLES		
Other receivables		
GST receivable from the Australian Taxation Office	49	83
Other amounts receivable	31	128
Total other receivables	80	211
Total trade and other receivables (gross)	80	211
Less impairment allowance	-	-
Total trade and other receivables (net)	80	211
Trade and other receivables (net) expected to be recovered		
No more than 12 months	80	211
More than 12 months	-	-
Total trade and other receivables (net)	80	211

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 2018. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

Note 2.2 Non-financial assets including fair value measurement

NOTE 2.2A: RECONCILIATION OF THE OPENING AND CLOSING BALANCES OF PROPERTY, PLANT AND EQUIPMENT, AND INTANGIBLES

	Buildings $'000	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 2017								
Gross book value	201	404	205	398	379	777	288	1,875
Accumulated depreciation, amortisation and impairment	-	(62)	(203)	(45)	-	(45)	(173)	(483)
Total as at 1 July 2017	201	342	2	353	379	732	115	1,392
Additions								
Purchase	151	5	-	-	-	-	-	156
Depreciation and amortisation	(60)	(71)	-	(179)	-	(179)	(38)	(348)
Disposals								-
Non-cash consideration	(28)	(57)	(17)	-	-	-	-	(101)
Work in progress transfers	-	-	-	379	(379)	-	-	-
Writeback of depreciation and other adjustments	28	57	17	-	-	-	-	101
Total as at 30 June 2018	292	276	2	553	-	553	77	1,200
Total as at 30 June 2018 represented by								
Gross book value	324	352	189	777	-	777	288	1,930
Accumulated depreciation, amortisation and impairment	(32)	(76)	(187)	(224)	-	(224)	(211)	(730)
Total as at 30 June 2018 represented by	292	276	2	553	-	553	77	1,200

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			Valuation technique(s) and inputs used[2]
	2018 $'000	2017 $'000	Category (Level 1, 2 or 3)[3,4]	
Non-financial assets[1]				
Buildings	**292**	201	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.
Plant and equipment	**276**	342	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 2018.

[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 2017.

[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:

	2018	2017
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 2018. 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 (2017: 1 to 4 years).

All software assets were assessed for indications of impairment as at 30 June 2018.

Fair value measurement

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

Note 2.3 Payables

	2018 $'000	2017 $'000
NOTE 2.3A: SUPPLIERS		
Trade creditors and accruals	**2,174**	2,543
Total suppliers	**2,174**	2,543

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

	2018 $'000	2017 $'000
NOTE 2.3B: OTHER PAYABLES		
Salaries and wages	**2**	8
Superannuation	**-**	1
Lease incentive	**-**	100
Lease payable	**5**	-
Total other payables	**7**	109
Other payables to be settled		
No more than 12 months	**2**	109
More than 12 months	**5**	-
Total other payables	**7**	109

Note 2.4 Other provisions

	2018 $'000	2017 $'000
Restoration provision at the beginning of the financial period	**186**	165
Unwinding of discount or change in discount rate	**-**	21
Reversal of restoration provision on lease expiry	**(186)**	-
Restoration provision on new lease arrangement	**151**	-
Total as at 30 June 2018	**151**	186

On the expiry of the office accommodation lease on 31 May 2018, a restoration provision of $0.186m was written back as no restoration was required. On 1 June 2018 IHPA entered into a new lease arrangement and a new restoration provision of $0.151m was raised together with a matching 'make good' asset.

Funding

This section identifies the IHPA's funding structure.

Note 3.1 Cash flow reconciliation

	2018 $'000	2017 $'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	**13,712**	9,793
Statement of financial position	**13,712**	9,793
Discrepancy	**-**	-
Reconciliation of net cost of services to net cash from operating activities		
Surplus	**4,048**	2,686
Adjustments for non-cash items		
Depreciation/amortisation	**348**	533
Make good asset on new lease arrangement	**(151)**	-
Net write down of non-financial assets	**-**	74
Lapsing receivable from Government	**-**	(18,176)
MOVEMENT IN ASSETS AND LIABILITIES		
Assets		
(Increase)/Decrease in net receivables	**131**	18,304
(Increase)/Decrease in prepayments	**101**	(205)
Liabilities		
Increase/(Decrease) in employee provisions	**(47)**	(962)
Increase/(Decrease) in suppliers' payables	**(369)**	612
Increase/(Decrease) in other payables	**(102)**	(678)
Increase/(Decrease) in other provisions	**(35)**	21
Net cash from operating activities	**3,924**	2,209

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

	2018 $'000	2017 $'000
NOTE 4.1A: EMPLOYEE PROVISIONS		
Leave	**76**	123
Total employee provisions	**76**	123
Employee provisions expected to be settled		
No more than 12 months	**12**	27
More than 12 months	**64**	96
Total employee provisions	**76**	123

Accounting policy

Employee provisions

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

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

Leave

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

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the entity's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave has been determined by reference to the work of an actuary as at 30 June 2018. 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.

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 Chief Executive Officer and the Pricing Authority members.

Key management personnel remuneration is reported in the table below:

	2018 $'000	2017 $'000
Short-term employee benefits	**737**	625
Post-employment benefits	**55**	73
Other long-term benefits	**20**	39
Termination benefits	**-**	-
Total key management personnel remuneration expenses[1]	**812**	*737*

The total number of key management personnel that are included in the above table is 12 (2017: 10).

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

Note 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 transactions entered into during the reporting period by the entity, it has been determined that there are no related party transactions to be separately disclosed.

Managing uncertainties

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

Note 5.1 Contingent assets and liabilities

Quantifiable contingencies

There were no quantifiable contingent assets or liabilities in this reporting period (2017: nil).

Unquantifiable contingencies

There were no unquantifiable contingent assets or liabilities in this reporting period (2017: nil).

Significant remote contingencies

There were no significant remote contingent assets or liabilities in this reporting period (2017: 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

	2018 $'000	2017 $'000
NOTE 5.2A: CATEGORIES OF FINANCIAL INSTRUMENTS		
Loans and receivables		
Cash and cash equivalents	**13,712**	9,793
Trade and other receivables	**31**	128
Total loans and receivables	**13,743**	9,921
Total financial assets	**13,743**	9,921
Financial liabilities		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	**2,174**	2,543
Total financial liabilities measured at amortised cost	**2,174**	2,543
Total financial liabilities	**2,174**	2,543

Accounting Policy

Financial assets

The entity classifies its financial assets in the following categories:

a. financial assets at fair value through profit or loss;

b. held-to-maturity investments;

c. available-for-sale financial assets; and

d. 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'.

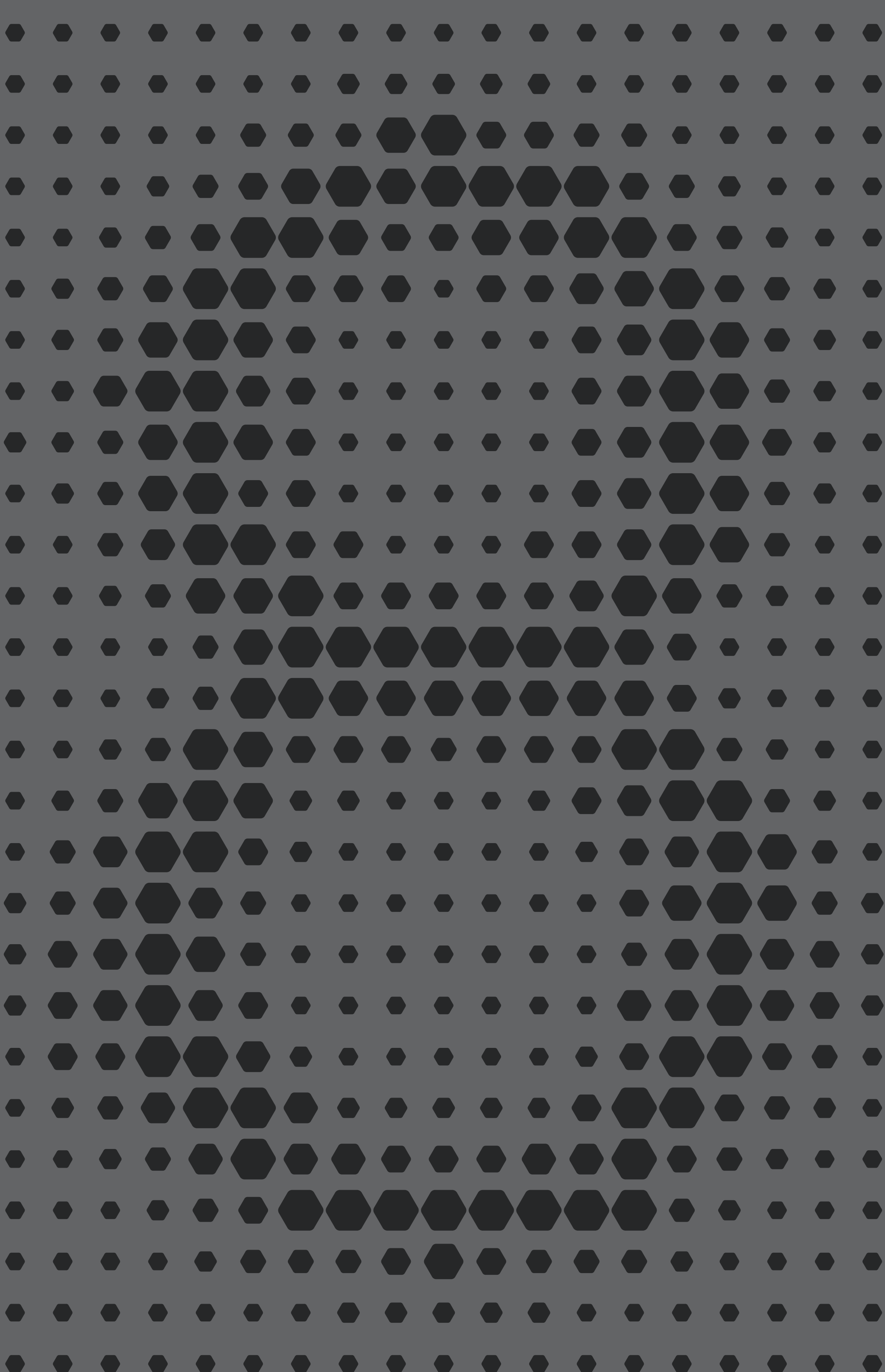
Financial liabilities at fair value through profit or loss

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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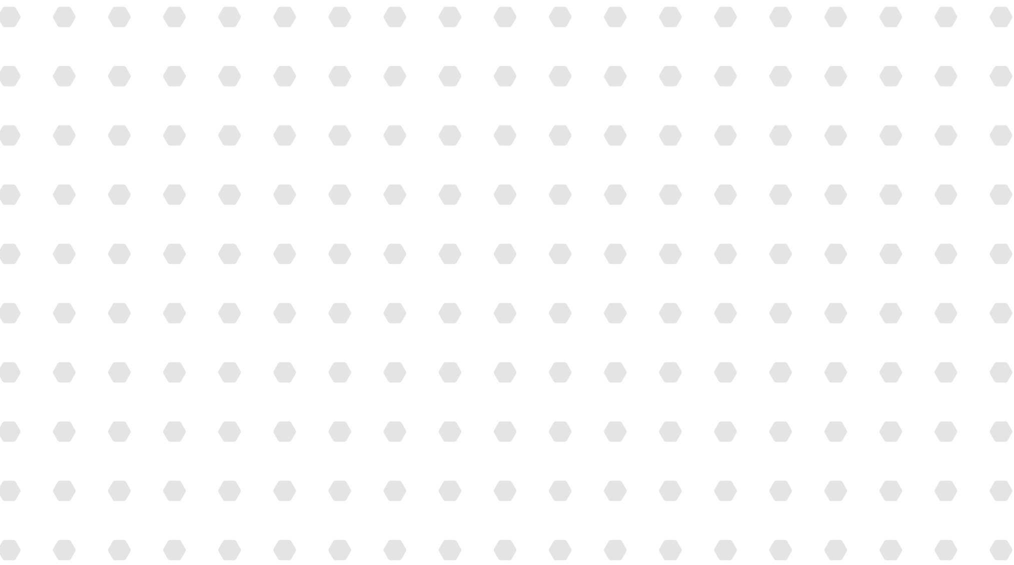

Appendix B: Acronyms and abbreviations

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

Appendix C: Glossary

Activity Based Funding

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

Australian Refined Diagnosis Related Groups

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

Back-casting

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

Block funding

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

Casemix

The number and type of patients treated in a hospital.

Council of Australian Governments (COAG)

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

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

Corporate Plan

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

Hospital acquired complication

A complication which occurs during a hospital stay such as falls, infections or pressure injuries. Clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The complete list of hospital acquired complications is available on the Australian Commission for Safety and Quality in Healthcare's website.

National Efficient Cost

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

National Efficient Price

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

National Health Reform Act 2011

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

National Health Reform Agreement

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

National Weighted Activity Unit (NWAU)

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

The average hospital service is worth one NWAU — the most intensive and expensive activities are worth multiple NWAUs, 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.

Sentinel event

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

Work Program

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

Appendix D: Compliance index

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

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Responsible Minister	4
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Significant non-compliance with finance law	N/A
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Statement on governance	12, 13
Related entity transactions	N/A
Significant activities and changes affecting the entity	N/A
Judicial decisions and reviews by outside bodies	N/A
Obtaining information from subsidiaries	N/A
Indemnities and insurance premiums	N/A
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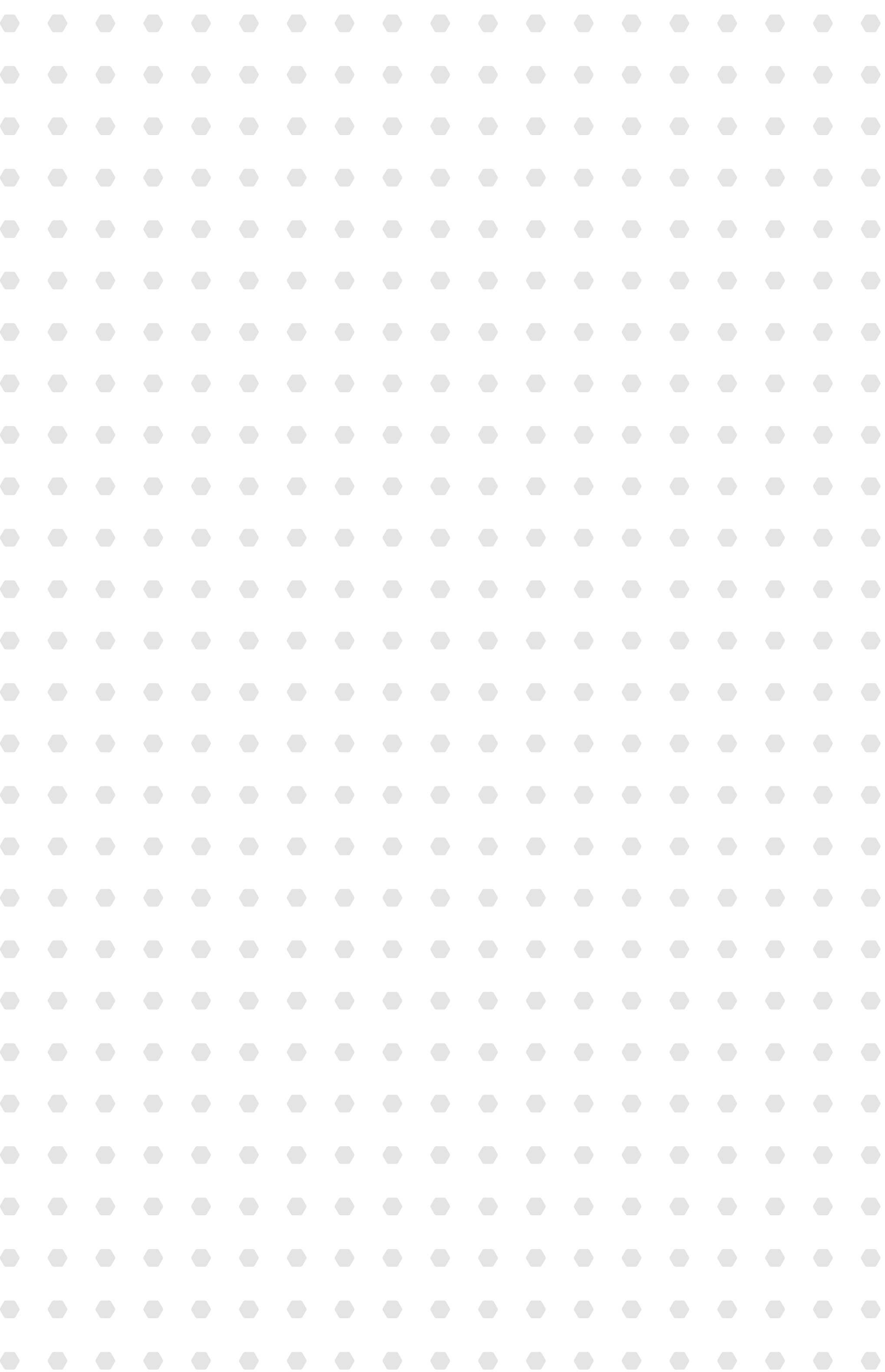

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