



IHACPA

Independent Health and Aged Care
Pricing Authority (IHACPA)

Annual Report

2025–26



Contact

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Acknowledgement of Country

We acknowledge the Traditional Owners and Custodians of Country throughout Australia, and recognise their continuing connection to land, sky, waters and culture. We pay our respects to them, and to Elders both past and present.

Artwork by Chern'ee Sutton

IHACPA Annual Report 2025–26

Online version

An online version of this annual report can be accessed at
<https://www.ihacpa.gov.au/ihacpa-annual-report-2025-26>

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The design of the front cover reflects IHACPA's visual identity with the use of its corporate logo and branded elements. These elements appear on the cover design and throughout the report.

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Online ISSN: 2981–8575
Print ISSN: 2981–8567

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Approval by accountable authority

The Independent Health and Aged Care 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.

Professor Michael Pervan

Chief Executive Officer

Independent Health and Aged Care Pricing Authority

18 September 2026

Table 1: Details of accountable authority during the current report period (2025–26)

Professor Michael Pervan



Position title	Date of commencement
Chief Executive Officer (CEO)	1 February 2023
Qualifications of the accountable authority	Date current appointment ends
Bachelor of Arts (Honours) UWA 1987	31 January 2028
Cert. Legal Studies ECU 1998	
Churchill Fellow 1998	Number of meetings of the Pricing Authority attended
Experience of the accountable authority	10
Professor Michael Pervan was appointed as CEO of IHACPA on 1 February 2023. Prior to this, Michael was Secretary of the Department of Natural Resources and Environment Tasmania, the Department of Communities Tasmania and the Department of Health where for nearly a decade he was responsible for designing and implementing major health sector and organisational reforms.	Executive / Non-executive member
Michael has represented Western Australia and Tasmania at the Australian Health Ministers Advisory Council and at the Council of Australian Governments' working groups on system reform, health workforce and mental health over a number of years.	Executive

Letter of transmittal



Ref: D26-32689

The Hon Mark Butler MP
Minister for Health and Ageing
Minister for Disability and the National Disability Insurance Scheme
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Minister,

On behalf of the Independent Health and Aged Care Pricing Authority (IHACPA), I am pleased to submit to you IHACPA's annual report and financial statements for the financial year ended 30 June 2026 for presentation to parliament.

The Annual Report 2025–26 has been prepared in accordance with the requirements of the *National Health Reform Act 2011* (the NHR Act), the *Public Governance, Performance and Accountability Act 2013* (the PGPA Act) and the Public Governance, Performance and Accountability Rule 2014 (the PGPA Rule).

The report's performance statements were prepared in accordance with the requirements of section 39 of the PGPA Act. The report includes the agency's audited financial statements, as required by section 42 of the PGPA Act.

As required by section 10 of the PGPA Rule, I certify that IHACPA has in place appropriate measures to prevent, detect and manage the risk and incidents of fraud.

Yours sincerely

Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
18 September 2026

cc. The Hon Sam Rae MP, Minister for Aged Care and Seniors

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Welcome from Pricing Authority Chair

I am pleased to present the Independent Health and Aged Care Pricing Authority's (IHACPA) Annual Report for 2025–26.

As Chair of the Pricing Authority, it has been a pleasure to guide the agency through another year as it commits to achieving its vision of a sustainable Australian care system that is accessible, resilient and delivers quality care outcomes for everyone.

National efficient price and cost determinations for public hospitals

Guided by comprehensive consultation with the jurisdictions and the public, IHACPA released its 2026–27 national efficient price and national efficient cost determinations in March.

The determinations reflect updates to key classifications to ensure they remain clinically relevant and aligned with current practice. This included refinements to pricing for admitted acute care such as new groupings for maternal care, organ donation after death, and new principles for consistent grouping of intervention-based episodes of care. It also saw the introduction of new classes for hospital-based, non-admitted voluntary assisted dying services.

Temporary measures to account for the impact of coronavirus disease (COVID-19) on public hospitals were removed from the determinations, reflecting that current activity and cost data now captures COVID-19 pandemic impacts. Another change that more accurately removes Pharmaceutical Benefits Scheme benefits from data collections has also been implemented, improving the alignment between prices and reported cost data.

Aged care pricing and costing advice

IHACPA's role in aged care pricing and costing advice remains essential to supporting high-quality, accessible care for older Australians.

IHACPA continues to strengthen its evidence base through ongoing collections and meaningful engagements across the aged care sector, supporting the development of pricing advice that more accurately reflects the cost of delivering residential and in-home aged care services.

I am pleased with IHACPA's progress in refining its approach to its aged care pricing and costing methodologies. Through strong collaboration and evidence-based decision making, IHACPA is responding to the evolving needs of Australia's ageing population.

Commendations

This year the Pricing Authority farewelled Mr Glenn Appleyard, who was a founding member of the Pricing Authority. His support and expertise made a significant contribution to IHACPA, and he was instrumental in establishing the strength of the Pricing Authority's processes and advice. I wish Mr Appleyard all the best in his future endeavours.

I extend my thanks to the members of the Pricing Authority for their engagement, sound judgment, time and expertise. I also recognise the many individuals and organisations, including Australian governments, public hospitals, aged care providers and other stakeholders, whose input supports IHACPA's efforts.

I would like to highlight the outstanding contributions made by our Aged Care Advisory Committee, Clinical Advisory Committee and Jurisdictional Advisory Committee, whose expert advice is essential to the decisions we make.

On behalf of the Pricing Authority, I extend my sincere thanks to all the staff at IHACPA and IHACPA's CEO. Their dedication, expertise and continued commitment to IHACPA's goals and vision have been instrumental in progressing the agency forward as a trusted price-setting institution in the care economy.

I look forward to working with the Pricing Authority, IHACPA CEO and staff, and our stakeholders to contribute further to the delivery of transparent, sustainable, efficient and high-quality hospital and aged care services for all Australians.



Mr David Tune AO PSM

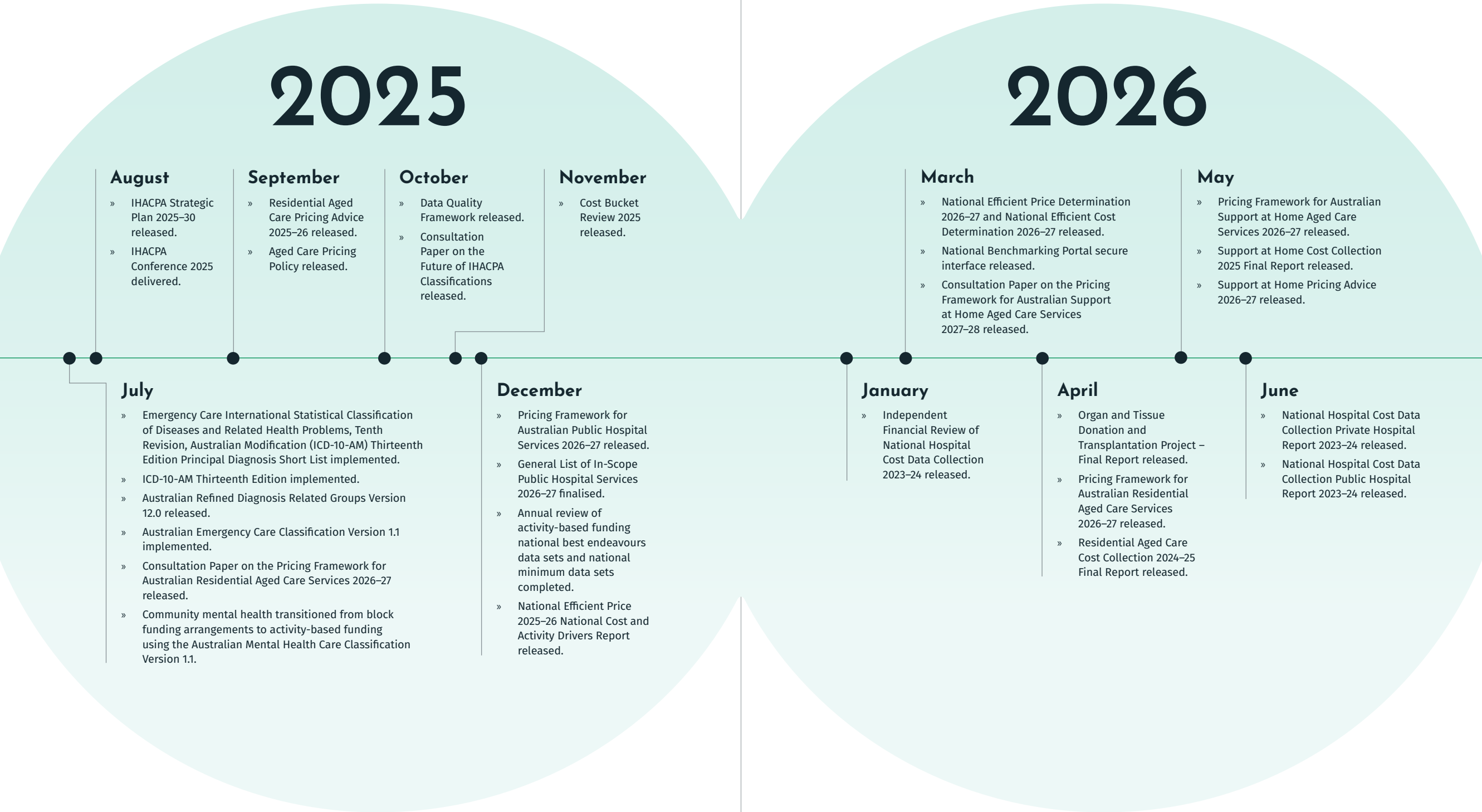
Chair

Independent Health and Aged Care Pricing Authority

2025–26 highlights

These are some of the key achievements from IHACPA's Work Program for 2025–26.

Figure 1 – 2025–26 highlights





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Overview

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1.1 Introduction

The Independent Health and Aged Care Pricing Authority (IHACPA) is an independent Commonwealth statutory authority established in 2011 under the [National Health Reform Act 2011](#) (NHR Act) to promote improved efficiency in, and access to, public hospital and aged care services. Our aged care functions under the [Aged Care Act 2024](#), which was introduced on 1 November 2025 include the assessment of applications from registered providers to charge accommodation payment amounts above the maximum amount determined by the Minister for Health and Ageing.

IHACPA is a corporate Commonwealth entity governed by the *Public Governance, Performance and Accountability Act 2013* (PGPA Act). The Chief Executive Officer of IHACPA is the accountable authority under the PGPA Act.

This annual report describes our operations and performance during 2025–26. The report was prepared in accordance with legislated reporting requirements under the PGPA Act.

In August 2025, we published our Strategic Plan 2025–30 outlining our vision, goals, purpose and the values that shape our work. These are outlined in **Figure 2**.

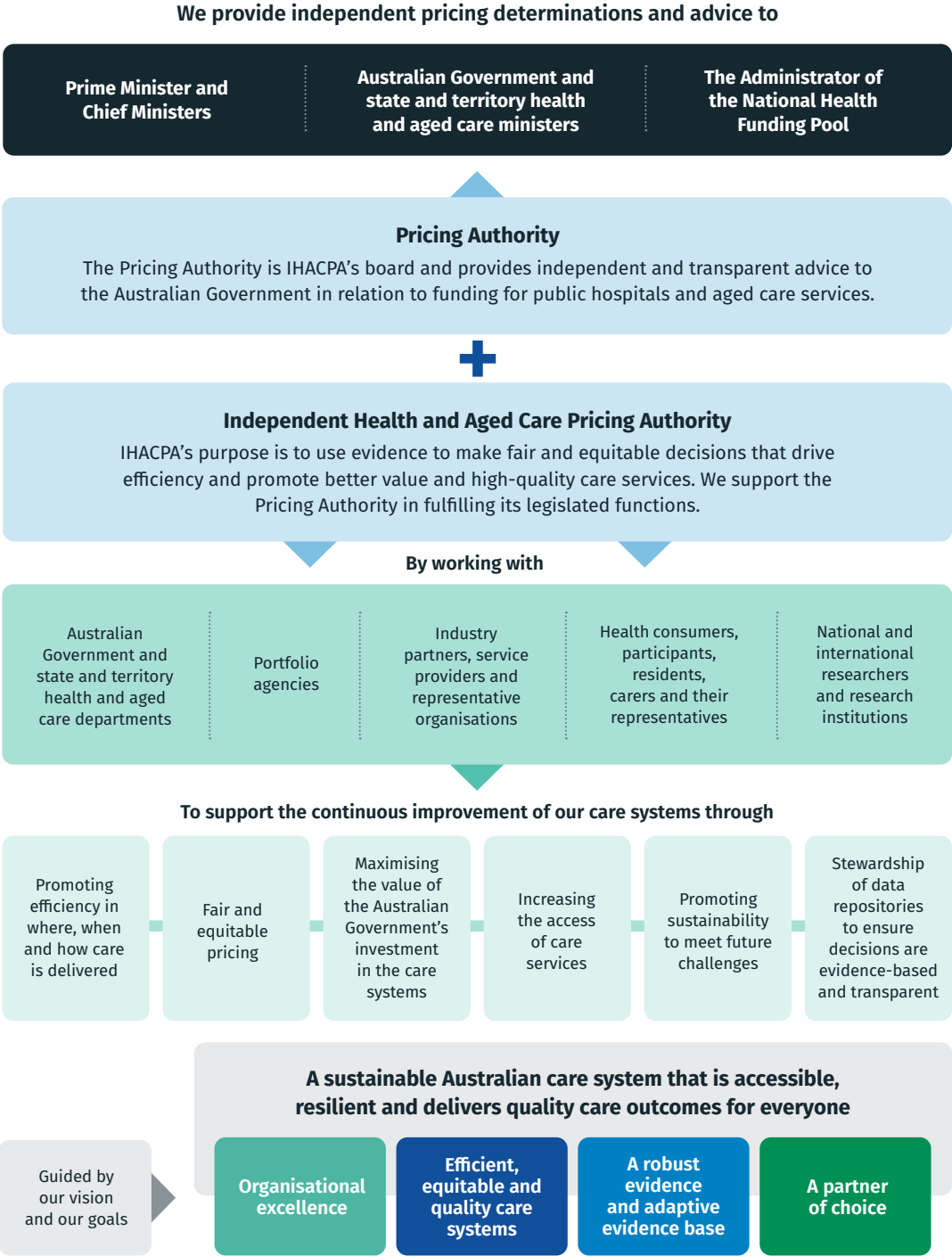
We are committed to making fair, equitable and evidence-based decisions and working with our stakeholders to reflect our broader vision for a care economy that is accessible, resilient and delivers quality outcomes for everyone. We engage stakeholders to inform policy and technical decisions, and provide clear, accessible information on the data and analysis underpinning them. Our role in the care economy is outlined in **Figure 3**.

Figure 2 – Our strategy

Our strategy



Figure 3: Our role in the care economy



1.2 What we do

Functions

Public hospitals

Our role in pricing and funding for public hospital services includes:

- » determining the national efficient price (NEP) for health care services provided by public hospitals where the services are funded on an activity basis
- » determining the national efficient cost (NEC) for health care services provided by public hospitals where the services are block funded
- » developing block funding criteria and determining which hospitals, services and functions are eligible for block funding or a combination of activity-based funding and block funding
- » developing and specifying classification systems for health care and other services provided by public hospitals
- » determining adjustments to the NEP to reflect legitimate and unavoidable variations in the costs of delivering health care services
- » determining data requirements, and the data and coding standards that apply to data provided by jurisdictions, including standards and requirements for:
 - consistent provision of data across jurisdictions
 - patient demographic characteristics and other information needed to classify, cost and fund public hospital functions
 - determining which public hospital functions are to be funded by the state or territory or by the Commonwealth – except where agreements are made between the Commonwealth and a state or territory.

On 27 February 2026, the Australian Government and all state and territory governments signed the Addendum to the National Health Reform Agreement (NHRA) 2026–2031 (the addendum).

The addendum provides an ambitious and broader system reform agenda, responding to increasing and persistent system pressures and demographic changes.

The addendum also reaffirms IHACPA's determinative functions under the NHR Act and introduces significant reforms, including:

- » articulating a broader reform vision focused on equity, productivity, sustainability and person-centred care
- » new models of care and alternative payment approaches
- » expansion of in-scope services beyond the hospital setting
- » new funding streams to trial, scale and embed innovation
- » Closing the Gap commitments embedded through governance and policy as core principles.

We are developing an implementation roadmap to manage our responsibilities under the addendum, which commence on 1 July 2026.

This annual report describes the operations and performance of IHACPA during the 2025–26 financial year and is based on the requirements set out in the NHR Act and the Addendum to the NHRA 2020–26.

Aged care

Our aged care pricing and costing functions include:

- » providing aged care pricing advice about changes in the cost of care and methods for calculating subsidies payable for aged care services
- » reviewing data, conducting studies and undertaking consultation to inform aged care pricing and costing advice
- » performing functions conferred by the *Aged Care Act 2024*¹ and the Aged Care Rules 2025, including the assessment of applications from registered providers to charge accommodation payment amounts above the maximum amount determined by the Minister for Health and Ageing
- » performing other functions relating to aged care specified in regulations
- » undertaking other actions incidental or conducive to the performance of these functions.

¹ On 1 November 2025, the *Aged Care Act 2024* came into effect, replacing the *Aged Care Act 1997*, *Aged Care (Transitional Provisions) Act 1997* and *Aged Care Quality and Safety Commission Act 2018*.

Provision of advice to the Australian Government on other health care pricing or costing matters

IHACPA also advises the Australian Government on other health care pricing or costing matters.

Investigate costs of radiation oncology services

In June 2025, the Minister for Health and Ageing requested that we investigate a reported disparity in the cost and funding of radiation oncology services under the NHRA.

This work aims to identify the true and full costs of public radiation oncology services and to consider the results of that cost review in relation to radiation oncology price weights determined by the Pricing Authority as part of its NEP determination.

The project commenced in November 2025 and is expected to be completed by March 2027.

Responsible minister

IHACPA sits within the Australian Government Health, Disability and Ageing portfolio.

The ministers responsible from 1 July 2025 to 30 June 2026 were the Hon Mark Butler MP, Minister for Health and Ageing and the Hon Sam Rae, Minister for Aged Care and Seniors.

Ministerial directions and government policy orders

We received a request from the Minister for Health and Ageing in October 2025 for pricing advice for each service and sub-service type on the Support at Home service list, applicable from 1 July 2026.

1.3 CEO's year in review

Once again, it is a privilege to highlight the dedication and exceptional standard of work demonstrated by IHACPA staff in this year's annual report.

It has been a significant year for the agency, delivering an extensive and impactful work program in a fast-paced environment. Throughout 2025–26, we have maintained a strong focus on innovation, collaboration and reform to support high-quality care across the health and aged care sectors.

Addendum to the National Health Reform Agreement 2026–31

In February 2026, the Australian Government and all state and territory governments signed the Addendum to the National Health Reform Agreement 2026–31. The addendum outlines significant reforms focused on equity, productivity, sustainability and person-centred care.

For IHACPA, this means a major effort to research, develop and support substantial reforms with the goal of achieving a more sustainable and responsive health system. This includes new models of care and alternative payment approaches. It also means the broadening of services beyond the hospital setting, enabling innovation through targeted funding streams and embedding Closing the Gap commitments as core principles underpinning governance and policy.

Key milestones 2025–26

Our Strategic Plan 2025–30 marks the first of its kind for our agency, outlining our vision, purpose, strategic goals and values. Released in August 2025, the plan was developed to provide staff with understanding of our long-term direction. The Strategic Plan is crafted for and by IHACPA staff, emphasising the importance of internal ownership in its adoption and implementation.

The Strategic Plan has been a key driver in the work progressed over 2025–26, with the first year of implementation demonstrating key strategic outcomes. Some of these achievements, as well as their alignment to the Strategic Plan, have been highlighted in this annual report.

IHACPA supported major aged care reforms following the commencement of the Support at Home program and the *Aged Care Act 2024*, including undertaking the Support at Home live data collection to improve the accuracy of cost and service delivery estimates across in-home care services.

We commenced funding model assessments for the Multi-Purpose Service Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, working closely with our stakeholders to develop evidence-based advice. This work forms part of a broader multi-year program aimed at establishing more sustainable and equitable funding arrangements that better meet the needs of diverse communities, leading to improved outcomes in aged care.

We also advanced work to support the potential transition to the International Classification of Diseases, Eleventh Revision (ICD-11). This will be a significant change to the way we develop classifications. This year saw further development of an ICD-11 business case, incorporating cost-benefit analysis and assessment of impacts, alongside targeted consultation with stakeholders to test assumptions and refine the evidence base.

Partnerships

In August, we hosted the IHACPA Conference 2025 in Adelaide. The conference featured a line-up of expert speakers who led discussions on reform, innovation, pricing and opportunities for harmonisation. The event brought together key players from the hospital, health care and aged care sectors to explore the resilience and sustainability of the growing care economy.

Throughout the year we have continued to strengthen partnerships with international organisations and universities to build technical expertise, support innovation, and develop workforce capability aligned with emerging global trends. Once again, we have hosted numerous international visits from countries following our work, many of whom have adopted our methods from classification structures to pricing methods. These engagements also support our ability to anticipate and respond to demographic changes across our own health and aged care sectors.

Thank you

I would like to take this opportunity to highlight the contributions made by our advisory committees, which enable us to improve the advice we provide to governments and the health and aged care sectors.

I would also like to acknowledge and thank the Chair of the Pricing Authority, Mr David Tune AO PSM, along with all members of the Pricing Authority, for their continued guidance, expert advice and support.

Finally, I wish to thank our dedicated IHACPA staff for their support and commitment to the agency's vision and goals, particularly as we continue to grow and change. I am honoured to lead an organisation with a diverse, resilient and highly skilled workforce that is instrumental in national health and aged care reforms.

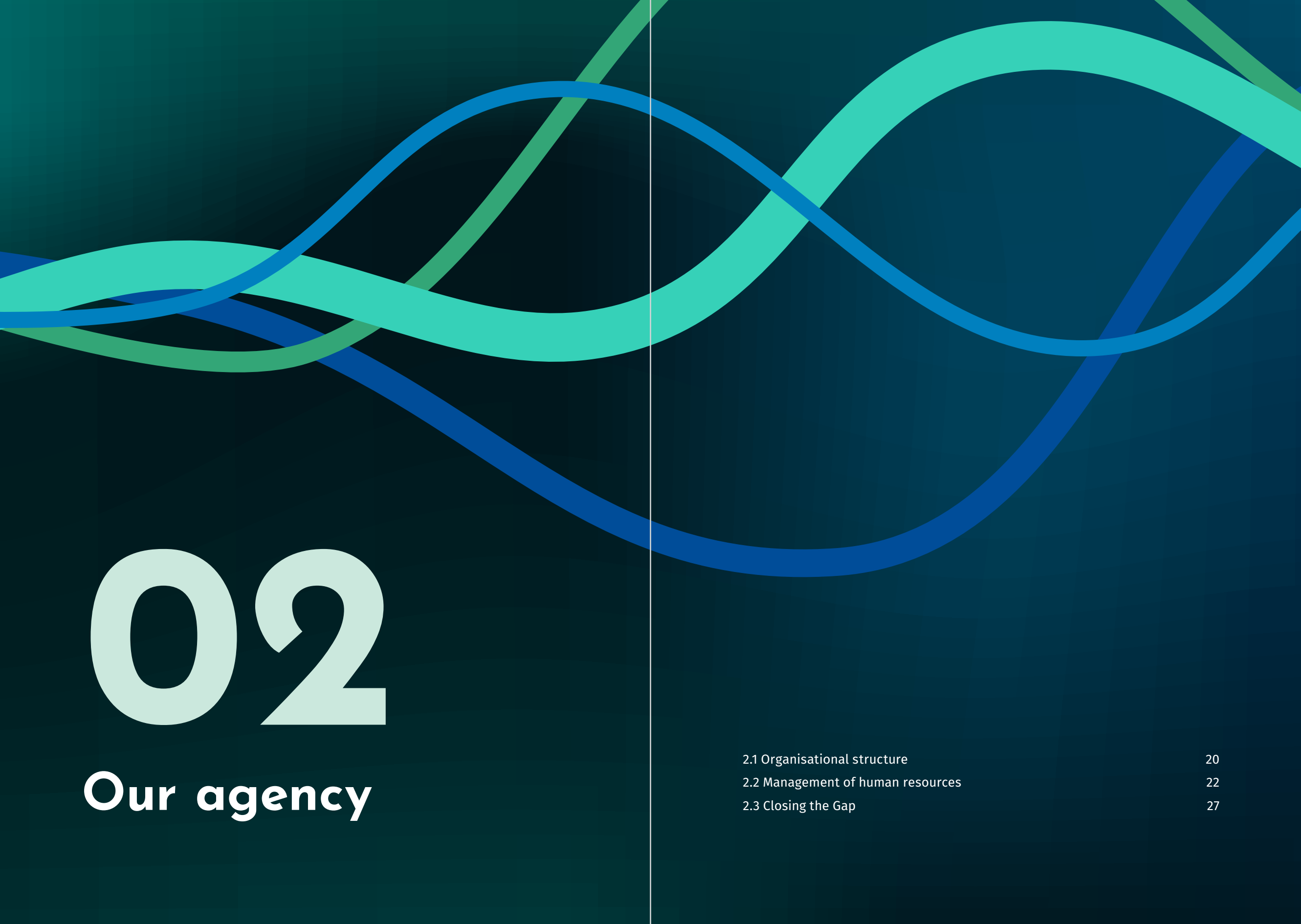
Sincerely,



Professor Michael Pervan

Chief Executive Officer

Independent Health and Aged Care Pricing Authority



02

Our agency

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2.1 Organisational structure

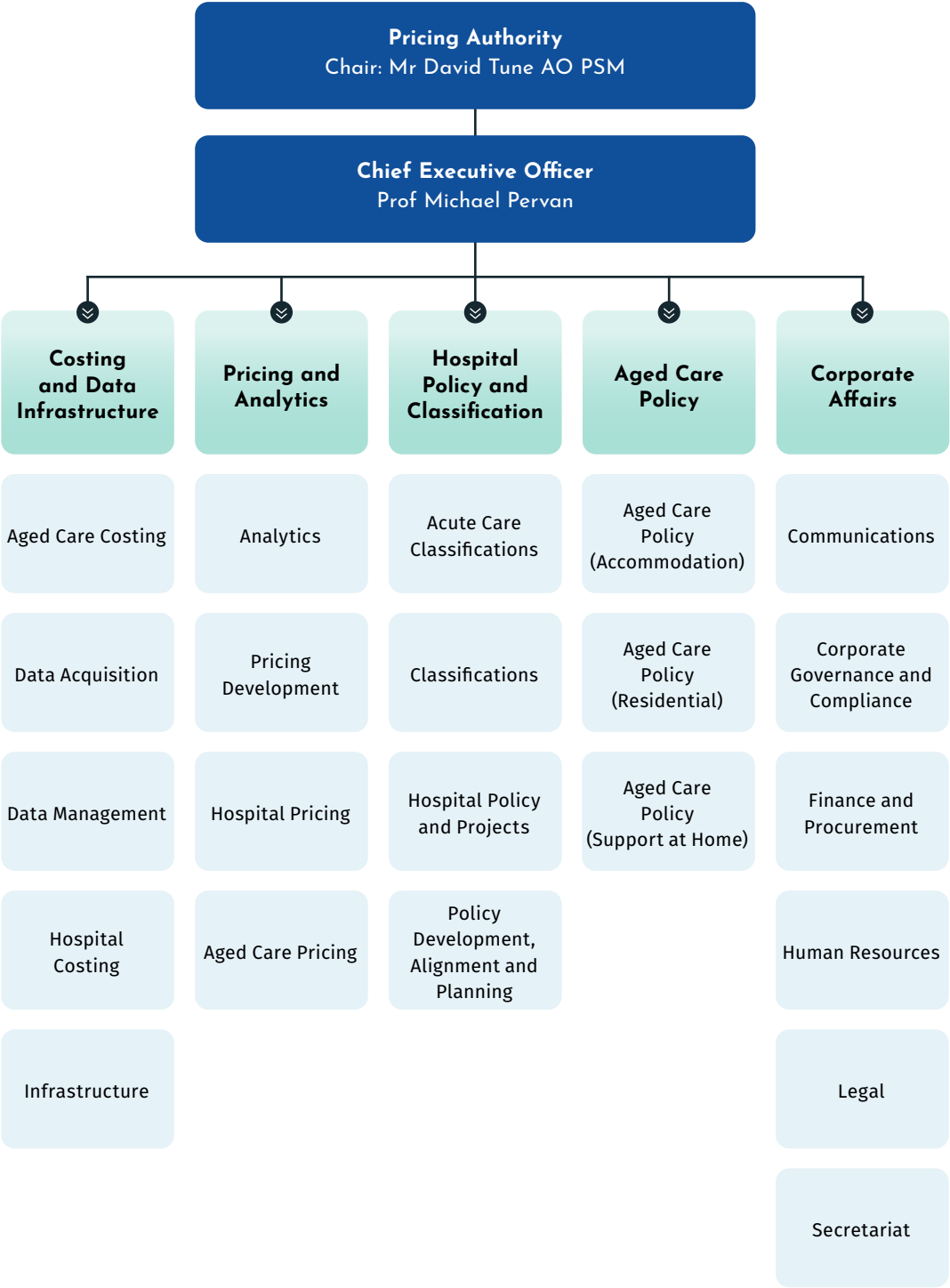
IHACPA is a corporate Commonwealth entity. The agency is governed by the Pricing Authority, consisting of a Chair, Deputy Chair (Hospital Pricing), Deputy Chair (Aged Care Pricing), and up to 6 other members. Our CEO is responsible for our operations and our staff.

See Chapter 3 for more information about the Pricing Authority.

Our organisational chart is depicted at **Figure 4**.

To achieve our annual program of work, we consult and collaborate with the Australian Government, state and territory governments, advisory committees, key stakeholders and the public.

Figure 4: IHACPA's organisational structure at 30 June 2026



2.2 Management of human resources

Our CEO is IHACPA's only employee and is based in Sydney, New South Wales. All other staff are seconded from the Australian Government Department of Health, Disability and Ageing. Staff work at the direction of the CEO under a memorandum of understanding with the department.

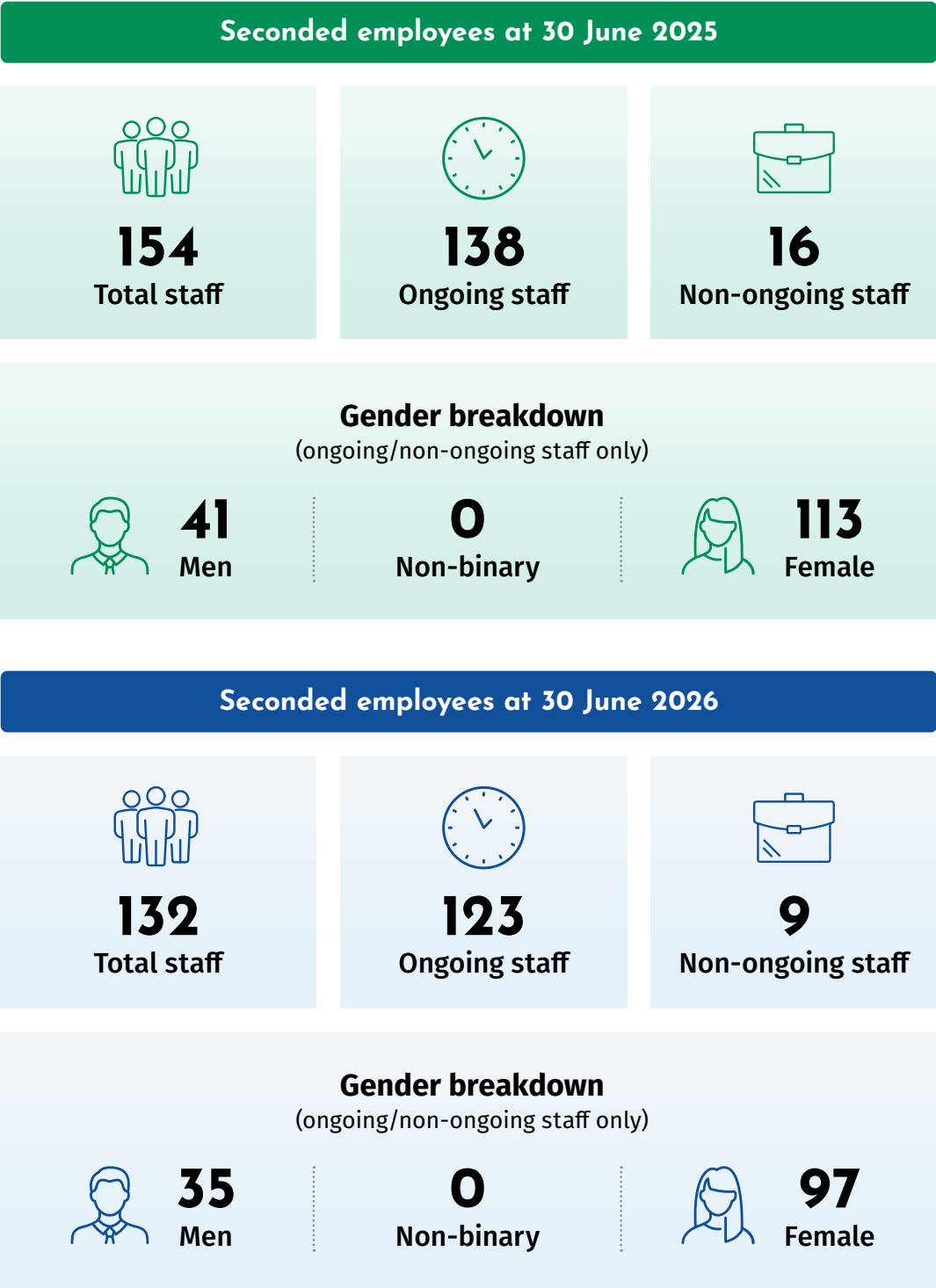
We place great value in creating a productive and inclusive workplace, where staff can optimise their work-life balance through flexible working arrangements, which are made seamless by effective technological support.

We have developed a Human Capital Plan to guide recruitment, development, engagement and retention of the people we need to meet our strategic objectives. This plan is being progressively implemented over a 3-year period, which commenced in 2025. The plan will be reviewed annually and updated as needed to reflect any future organisational changes or challenges.

Our workforce statistics at a glance

We are committed to the recruitment and retention of a diverse workforce (for example, in gender, age, cultural and linguistic background, disability, indigeneity and LGBTIQI+) and actively promote an inclusive workplace culture. **Figure 5** presents a summary of the composition of our workforce. The full workforce statistics for our staff is available in Appendix C.

Figure 5: IHACPA's workforce statistics



Staff development

We cultivate, value and support staff by developing their skills and capabilities to meet their work requirements and achieve their full potential. We also promote a culture where people work within and across teams to broaden their expertise.

In 2025–26, we supported individuals to undertake higher education, attend training and conferences, and develop their capabilities through on-the-job learning opportunities like higher duties and participation in team projects. Our training investment for the year averaged \$1,114 per staff member.

Education and training

Individual staff were able to access training that meet their job requirements or career aspirations as part of their performance development plans. This included the following:

- » Administrative Decision Making
- » Artificial Intelligence in Government Fundamentals
- » Integrity and Fraud Prevention
- » neurodiversity awareness
- » procurement.

Work health and safety

Under the [Work Health and Safety Act 2011](#) (WHS Act), we have a duty to ensure the health and safety of our workers and other persons, and to take reasonably practicable steps to eliminate or minimise health and safety risks. To satisfy this duty and ensure a productive work environment, we commit to take all reasonably practicable steps to provide:

- » safe systems of work and working conditions
- » education on safe working practices
- » information on, and control measures for, hazards in the workplace.

We have a number of health and wellbeing initiatives and programs in place, including:

- » ergonomic workstation assessments, which were conducted for all new staff and existing staff as required
- » access to an Employee Assistance Program
- » flu vaccination program
- » flexible working options to balance professional and personal commitments
- » time off during work hours to donate blood.

In 2025–26, our Work Health and Safety Committee continued to manage work health and safety matters in accordance with the WHS Act.

The committee met 4 times during the year and dealt with a range of work health and safety matters. Quarterly workplace inspections were conducted by health and safety representatives.

In 2025–26, no notifiable work health and safety incidents were identified, and 4 work health and safety investigations were conducted. Additionally, no injuries to employees were reported during the year.

Each year Comcare undertakes proactive inspections of Commonwealth agencies under the WHS Act. One inspection was undertaken in 2025–26, which focused on work health and safety risk management. There were no adverse findings and Comcare confirmed we had systems in place to consult, coordinate and cooperate with workers and other duty holders in our workplace.

Advertising and market research

In 2025–26, we did not conduct any advertising campaigns.

Key management personnel

Key management personnel (KMP) are those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly. IHACPA has determined KMP to be the Chief Executive Officer and the Pricing Authority members. The table below is in accordance with the Public Governance, Performance and Accountability Rule 2014.

Table 2: Remuneration of KMP 2025–26

	Name	Position Title	Short-term benefits			Post employment			Other long-term benefits			Total benefits remuneration
			Base salary	Bonuses	Other benefits and allowances	Superannuation contributions	Long-term leave	Other service benefit	Termination			
			\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	Mr Glenn Appleyard ²	Pricing Authority member	41,718	-	-	-	6,425	-	-	-	-	48,143
	Dr Adam Coltzau	Pricing Authority member	53,181	-	-	-	6,382	-	-	-	-	59,563
	Ms Prudence Ford	Pricing Authority member	53,181	-	-	-	6,382	-	-	-	-	59,563
	Distinguished Prof Jane Hall AO	Pricing Authority member	53,181	-	-	-	6,382	-	-	-	-	59,563
	Prof Maria Inacio	Pricing Authority member	53,181	-	-	-	6,382	-	-	-	-	59,563
	Dr Stephen Judd AM	Pricing Authority member: Deputy Chair (Aged Care Pricing)	79,757	-	-	-	9,571	-	-	-	-	89,328
	Prof Michael Pervan	Chief Executive Officer	589,186	-	-	-	30,169	14,008	-	-	-	633,363
	Mr David Tune AO PSM	Pricing Authority member: Chair	106,342	-	-	-	12,761	-	-	-	-	119,103
	Ms Jennifer Williams AM	Pricing Authority member: Deputy Chair (Hospital Pricing)	79,757	-	-	-	9,571	-	-	-	-	89,328
	Total		1,109,484				94,025	14,008				1,217,517

² Mr Appleyard resigned from the Pricing Authority on the 31 March 2026.

2.3 Closing the Gap

In 2025–26, we continued to support the implementation of the [Closing the Gap Priority Reforms](#) and to advance efforts to improve outcomes for Aboriginal and Torres Strait Islander people.

Priority Reforms

Priority Reform 1: Formal partnerships and shared decision-making

We established the Aged Care Network (ACN) in August 2025, with membership including several Aboriginal and Torres Strait Islander organisations from both government and community sectors. The ACN enables us to seek targeted feedback and input on a broad range of relevant aged care matters and supplements existing formal consultation processes.

In December 2025, we finalised our Stakeholder Engagement Plan 2025–27 which notes that strengthening engagement with First Nations stakeholders is a core priority for us, reflecting our commitment to foster sustainable and inclusive practices.

Priority Reform 2: Building the community-controlled sector

Currently, Aboriginal Community Controlled Health Organisations (ACCHOs) are not considered in-scope for public hospital services. The [Addendum to the National Health Reform Agreement \(NHRA\) 2026–31](#) requires IHACPA to review funding models to better support and incentivise ACCHOs delivering in-scope hospital services. We will investigate formal partnership arrangements with Aboriginal and Torres Strait Islander people and the Aboriginal and Torres Strait Islander health sector to review funding models.

Priority Reform 3: Transforming government organisations

In 2025–26, we participated in Reconciliation Week and NAIDOC Week events run by our Social Committee.

In 2025, we developed a First Nations Graphic Artwork Style Guide to support the respectful and appropriate use of First Nations artwork across our agency. Bespoke artwork by First Nations artist Chern’ee Sutton is used across internal and external publications, digital assets, Acknowledgment of Country materials and a framed artwork story is mounted in the Sydney office.

Priority Reform 4: Shared access to data and information at a regional level

In November 2025, we published the [Pricing for Australian public hospital services for First Nations peoples – Fact sheet](#), which outlines our role under the NHRA in relation to public hospital services for First Nations peoples. The fact sheet explains how we calculate and determine the national efficient price (NEP) and the national efficient cost for the Australian public hospital system, including the Indigenous adjustment applied to the NEP.



03

Governance and accountability

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3.1 The Pricing Authority

The Pricing Authority provides independent and transparent advice to the Australian Government in relation to the pricing of public hospital and aged care services. The Pricing Authority has an overall governance role and is responsible for the proper and efficient performance of IHACPA's functions.

Pricing Authority members are appointed for a period of up to 5 years and can be reappointed. The Chair and Deputy Chair (Aged Care Pricing) are appointed by the Minister for Health and Ageing. The Deputy Chair (Hospital Pricing) is appointed by the minister with the agreement of first ministers of all states and territories. The remaining members are appointed with the agreement of the Prime Minister and first ministers of the states and territories.

Members bring significant and varied expertise to their roles, including substantial experience and knowledge of the health and aged care sectors, health care needs, and the provision of these services in regional and rural areas.

The Pricing Authority is supported by the CEO, who manages IHACPA's operations. All Pricing Authority members are non-executive.



Mr David Tune AO PSM, Chair

Mr David Tune AO PSM was appointed Chair of the Pricing Authority with effect from 1 February 2022.

He was formerly Chair of the Aged Care Sector Committee that provided advice to the Commonwealth Government on aged care from early 2015 to July 2021.

He has undertaken many reviews for the Commonwealth and state governments, including the Legislative Review of Aged Care in 2016.

Mr Tune was Secretary of the Australian Government Department of Finance from 2009 until 2014.



Ms Jennifer Williams AM, Deputy Chair, Hospital Pricing

Ms Jennifer Williams AM is an experienced board member serving on several health service related boards. She recently completed 10 years as the Chair of Northern Health and completed her term as Chair of Yooralla in 2024–25 after 9 years.

Her other board appointments were with Barwon Health and the Victorian Health Building Authority Advisory Board. Ms Williams 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 considerable experience in the health sector over several decades, working across the hospital, aged care and community sectors.



Dr Stephen Judd AM, Deputy Chair, Aged Care Pricing

Dr Stephen Judd was Chief Executive of health and aged care services provider, HammondCare, from 1995–2020. When he stepped down, HammondCare had grown to provide care and services to more than 25,000 clients.

He has written and contributed to books on dementia care, aged care design and the role of charities in contemporary Australian society. He has served on numerous government and industry committees. Until 2020, he was a member of the Advisory Council of the Australian Aged Care Quality Agency.

Dr Judd has served as a Senior Visiting Fellow at the School of Population Health, UNSW Medicine, University of New South Wales and as the inaugural Fellow, Council on the Ageing, a peak consumer advocacy group, until the end of 2022.



Mr Glenn Appleyard

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

He 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 Chair of the Tasmanian Economic Regulator.

Mr Appleyard resigned from his position on the Pricing Authority on 31 March 2026. As a founding member of the Pricing Authority, his contribution and expertise made a significant contribution to IHACPA and were instrumental in establishing the strength of the Pricing Authority's processes and advice.



Ms Prudence Ford

Ms Prudence Ford is a member of the Health Consumers' Council of Western Australia. She was an inaugural member of the Medical Board of Australia and has previously been a member of the National Blood Authority, the National Health and Medical Research Council, the Brightwater Care Group Board (a provider of aged and disability care services) and the Western Australian Medical Board.

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



Dr Adam Coltzau

Dr Adam Coltzau is the Director of Medical Services at St George Hospital in rural Queensland.

He is a rural generalist with extensive experience in hospital management, aged care and Aboriginal and Torres Strait Islander Health.

Dr Coltzau is a Fellow of both the Royal Australian College of General Practitioners and Australian College of Rural and Remote Medicine. He is also a senior clinical lecturer at the University of Queensland Rural Clinical School and general practitioner training supervisor.

He served as President and on the boards of the Rural Doctors Association of Queensland and the Rural Doctors Association of Australia.

Dr Coltzau also served as the inaugural Chair of the Board of the Rural Doctors Foundation, which he helped establish.



Distinguished Professor Jane Hall AO

Professor Jane Hall AO is a Distinguished Professor of Health Economics at the University of Technology Sydney, and Honorary Professor at the Leeder Centre for Health Policy, Economics and Data. She received the National Health and Medical Research Council Outstanding Contribution Award in 2017 and was named as one of the Australian Financial Review/ Westpac 100 Women of Influence in 2016.

Professor Hall is a Fellow of the Academy of Social Sciences in Australia, where she previously served as President, and of the Australian Academy of Health and Medical Sciences.

She has worked across many areas of health economics. Her current research is focussed on funding and financing issues and payment reform.



Professor Maria Inacio

Professor Maria Inacio is an epidemiologist with expertise in population health surveillance, aged and health care services research. She is the Director of the Registry of Senior Australians (ROSA) Research Centre at the South Australian Health and Medical Research Institute, Matthew Flinders Professor of Health Services and Epidemiology at Flinders University Caring Futures Institute and a National Health and Medical Research Council Fellow.

Since 2017, Professor Inacio has led the ROSA Research Centre, which includes a multidisciplinary team of over 30 researchers dedicated to creating high-quality evidence to improve the quality of care and ageing for older people. She has been awarded several competitive grants, including multiple grants as Chief Investigator from national funding bodies such as the National Health and Medical Research Council and Medical Research Future Fund, and has published over 265 scientific articles.

Meetings of the Pricing Authority 2025–26

The Pricing Authority met on 10 occasions between 1 July 2025 and 30 June 2026. Our CEO, Professor Michael Pervan, attended 10 meetings as the accountable authority.

Table 3: Meetings of the Pricing Authority 2025–26

Member	Meetings eligible	Meetings attended
Mr David Tune AO PSM, Chair	10	8
Ms Jennifer Williams AM, Deputy Chair, Hospital Pricing	10	8
Dr Stephen Judd AM, Deputy Chair, Aged Care Pricing	10	8
Mr Glenn Appleyard ³	7	5
Ms Prudence Ford	10	9
Dr Adam Coltzau	10	9
Distinguished Professor Jane Hall AO	10	8
Professor Maria Inacio	10	10

³ Mr Appleyard resigned from his position on the Pricing Authority, effective 31 March 2026.

3.2 Committees and working groups

IHACPA has established a comprehensive committee framework. These committees provide us with expert advice and support transparent delivery of our work program.

Our statutory committees are the Clinical Advisory Committee, the Aged Care Advisory Committee and the Jurisdictional Advisory Committee. These committees are established under sections 4.10, 4.11A and 4.11 of the *National Health Reform Act 2011* (NHR Act).

Other advisory committees and working groups have been established under Part 4.12 of the NHR Act to assist us in performing our functions. These include:

- » Activity Based Funding Technical Advisory Committee
- » Classifications Clinical Advisory Group
- » Diagnosis Related Groups Technical Group
- » Emergency Care Advisory Working Group
- » International Classification of Diseases Technical Group
- » Mental Health Working Group
- » National Hospital Cost Data Collection (NHCDC) Advisory Committee
- » Non-Admitted Care Advisory Working Group
- » Private Sector NHCDC Working Group
- » Small Rural Hospitals Working Group
- » Stakeholder Advisory Committee⁴
- » Subacute Care Working Group
- » Teaching, Training and Research Working Group.

Our committees and working groups are structured to support the effective delivery of our statutory functions and work program. Some committees and working groups are supported by sub-committees where required. Each committee and working group has terms of reference that set out its role, functions, membership and reporting arrangements.

⁴ The Stakeholder Advisory Committee was retired in April 2026.

The CEO has also established internal committees to support the internal management of the agency and its staff. These include:

- » Audit, Risk and Compliance Committee
- » Data Governance Steering Committee
- » Executive Committee
- » Work Health and Safety Committee.

Jurisdictional Advisory Committee

The Jurisdictional Advisory Committee (JAC) was established under section 195 of the NHR Act. It consists of a Chair, appointed by the Pricing Authority (currently our CEO) and 9 other members. Members represent each state and territory and the Department of Health, Disability and Ageing.

Committee members are appointed by the head of the health department of the jurisdiction they represent.

JAC met on 7 occasions between 1 July 2025 and 30 June 2026.

As at 30 June 2026, members of JAC comprised:

- » Prof Michael Pervan (Chair)
- » Ms Caitlin O'Brien (Australian Government)
- » Ms Elizabeth Wood (New South Wales)
- » Dr Andrew Haywood (Victoria)
- » Vacant position (Queensland)
- » Ms Julianne TePohe (South Australia)
- » Mr Timothy Nelson (Western Australia)
- » Mr Shane Bond (Tasmania)
- » Ms Kirsty Annesley (Northern Territory)
- » Ms Skye Jacobi (Australian Capital Territory).

During the reporting period, there were changes to the Australian Government, Northern Territory, Queensland, Tasmania and Western Australia memberships.

3.3 Clinical Advisory Committee

Letter from the Chair

As Chair of the Clinical Advisory Committee, I am pleased to reflect on another productive year of collaboration and achievement in support of IHACPA's important work.

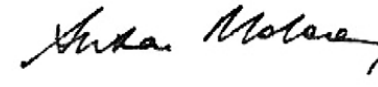
Throughout 2025–26, the committee provided advice to inform the refinement of IHACPA's pricing models, including the hospital acquired complications and avoidable hospital readmissions risk adjustment models. The committee's expertise also contributed to the review of risk factors, helping to ensure that pricing arrangements continue to support improved patient outcomes.

As part of the ongoing development and refinement of IHACPA's health classifications, the committee played a key role. This included providing advice on the methodology of grouping diagnoses within the Australian Emergency Care Classification, as well as contributing to the development of a new non-admitted care classification through the Australian Non-Admitted Patient Classification Project. In addition, members supported broader classification improvement activities, including advice on the classification of new interventions and clinical coding queries.

In February 2026, a significant milestone saw the signing of the Addendum to the National Health Reform Agreement 2026–31 by the Australian Government and all state and territory governments. The committee worked closely with IHACPA to consider the implications of the reforms. This included future work on the development of a new funding models framework, enhancements to pricing adjustment methodologies and approaches to better support partnerships and integration across the health system. The reforms present an important opportunity to strengthen incentives for high-quality, coordinated care and improve outcomes for patients. The committee looks forward to continuing our contribution to this work.

I would like to sincerely thank the Pricing Authority, IHACPA's Chief Executive Officer and staff for their ongoing commitment, expertise and collaborative approach. Their dedication has been instrumental in delivering an ambitious and comprehensive program of work throughout the year.

It is an honour to serve as Chair of this committee. I look forward to continuing to work alongside IHACPA and my fellow committee members to support a health system that is clinically sound, efficient, sustainable and focused on achieving the best possible outcomes for all Australians.



Professor Susan Moloney

Chair, Clinical Advisory Committee

About the Clinical Advisory Committee

The Clinical Advisory Committee (CAC) is a statutory committee established under section 176 of the NHR Act. Under section 177 of the NHR Act, the committee’s functions are to:

- » advise the Pricing Authority in relation to developing and specifying classification systems for health care and other services provided by public hospitals
- » advise the Pricing Authority on matters that relate to the functions of the Pricing Authority, or are referred to the CAC by the Pricing Authority
- » do anything incidental to, or conducive to, the performance of the above functions.

CAC 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 policy development. This advice informs the annual determination of the national efficient price and national efficient cost.

As at 30 June 2026, CAC consisted of 18 members. Details of the committee’s membership and meetings are shown in **Table 4**.

CAC is required to report on its work annually.

Membership

CAC members are appointed by the Minister for Health and Ageing. Members are from a range of clinical specialties and backgrounds, to ensure the committee adequately represents a wide range of clinical expertise. All jurisdictions are consulted before any appointments are recommended to the minister.

Table 4: Membership and meetings of the Clinical Advisory Committee in 2025-26

Name	Position	Specialty	Meetings eligible	Meetings attended
Prof Susan Moloney	Chair	Paediatrics	4	4
Ms Nicole Carter (nee Harwood)	Member	Nursing	2	0
Mr Christopher O’Donnell	Member	Nursing	2	0
A/Prof Nicole Phillips	Member	Administration/anaesthesia and pain management	4	3
A/Prof Virginia Plummer	Member	Nursing	4	4
Ms Amber Polles	Member	Pharmacy	4	4
Dr Tracy Smith	Member	Respiratory and palliative care	4	3
Dr Jo Wright	Member	Rural medical practice	4	3
Dr Kathryn Zeitz	Member	Nursing	4	0
Clinical Prof Jenny Deague	Member	Cardiology	4	3
Dr Richard Phoon	Member	Nephrology	4	3
Dr Amith Shetty	Member	Emergency care	4	3
Dr Marco Briceno	Member	Indigenous health	4	2
Dr Didier Palmer	Member	Emergency care	4	1
Prof Susan Kurrie	Member	Gerontology	4	3
Dr Nhi Nguyen	Member	Intensive Care	4	4
Dr Lisa Kelly	Member	Geriatric medicine	4	3
Mr Andric Lu	Member	Allied health	4	4
Mr Sandeep Gupta	Member	Allied health	4	3
A/Prof Sharon Carey	Member	Allied health	4	2

Clinical Advisory Committee meetings 2025–26

30 July 2025

22 October 2025

5 February 2026

16 April 2026

3.4 Aged Care Advisory Committee

Letter from the Chair

As Deputy Chair, Aged Care Pricing, of the Pricing Authority and Chair of the Aged Care Advisory Committee, I am pleased to present this letter outlining our contributions during 2025–26.

Throughout the year, the committee continued to provide valuable feedback and advice on aged care pricing and costing matters. Committee members contributed to the Residential Aged Care Pricing Advice 2026–27 as well as costing advice on the Australian National Aged Care Classification funding model.

It was a year of significant changes, with the *Aged Care Act 2024* commencing on 1 November 2025. This established the Support at Home program, replacing the Short-Term Restorative Care Programme and the Home Care Packages Program. Committee members provided input into the Support at Home Pricing Advice 2026–27 and costing advice, supporting an evidence-based approach for the new program.

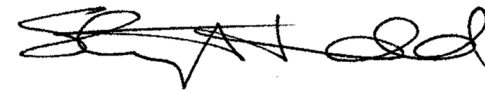
This year, we also strengthened engagement with our partners with the establishment of the Aged Care Network. The network is a consultative forum where we seek targeted expert feedback and input into IHACPA's annual aged care work program. Members include aged care professionals, complementing our existing public consultations while supporting effective communication with the sector.

In September 2025, the Aged Care Pricing Policy was released. The policy provides transparency and clarity by outlining IHACPA's principles, processes and approach to developing pricing advice across residential aged care, residential respite care and in-home aged care.

In addition, I acknowledge the valuable feedback provided by committee members on the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Multi-Purpose Service Program funding model assessments. These have been delivered to government and will inform development of advice and recommendations on any improvements to future funding models.

I extend my thanks to my fellow committee members for their high levels of engagement and contributions during our meetings this year. I also wish to acknowledge the expertise and dedication of IHACPA staff, whose efforts have been integral in supporting the committee's work throughout the year.

I look forward to the year ahead and to our continued contribution to the Pricing Authority's aged care advice.



Dr Stephen Judd AM

Deputy Chair, Aged Care of the Pricing Authority
and Chair of the Aged Care Advisory Committee

About the Aged Care Advisory Committee

The Aged Care Advisory Committee (ACAC) is a statutory committee established under section 204A of the NHR Act. Under section 204B, the committee’s functions are to:

- » advise the Pricing Authority in relation to the development of aged care pricing or costing advice
- » advise the Pricing Authority on matters that relate to the functions of the Pricing Authority, or are referred to the ACAC by the Pricing Authority
- » do anything incidental to, or conducive to, the performance of the above functions.

ACAC informs the Pricing Authority’s decision making on the relevant factors associated with the delivery of care and services in residential aged care, residential respite care and in-home aged care. The committee also provides advice on the inputs to the development of pricing advice.

As at 30 June 2026, ACAC consisted of 7 members. Details of the committee’s membership and meetings are shown in **Table 5**.

ACAC is required to report on its work annually.

Membership

ACAC members are appointed by the Minister for Health and Ageing. Members are from a range of specialties and backgrounds, to ensure the committee represents a wide range of aged care expertise.

Table 5: Membership and meetings of the Aged Care Advisory Committee in 2025–26

Name	Position	Meetings eligible	Meetings attended
Dr Stephen Judd	Chair	3	2
Ms Rowan Cockerell	Member	3	3
Professor Maria Inacio	Member	3	3
Dr Martin Lavery	Member	3	2
Mr Nicolas Mersiades	Member	3	2
Professor Julie Ratcliffe	Member	3	2
Professor Michael Woods	Member	3	3

Aged Care Advisory Committee meetings 2025–26

4 August 2025

11 November 2025

13 May 2026

3.5 Key corporate governance practices

Audit, Risk and Compliance Committee

The Audit, Risk and Compliance Committee (ARCC) provides independent advice to the CEO on managing IHACPA’s financial and business risk.

The ARCC Charter is available at ihacpa.gov.au/audit-risk-and-compliance-committee.

ARCC met on 4 occasions between 1 July 2025 and 30 June 2026. CEO Professor Michael Pervan attended 4 meetings. Details of the committee’s membership and meetings are shown in **Table 6**.

During the reporting period, members of the ARCC comprised:

- » Ms Angela Diamond, Chair and independent member
- » Mr Glenn Appleyard⁵, member, Pricing Authority member
- » Distinguished Professor Jane Hall AO, Pricing Authority member
- » Mr John Lenarduzzi, independent member
- » Ms Yaso Arumugam, independent member.

⁵ Mr Appleyard resigned from his position on the Pricing Authority, effective 31 March 2026.

Table 6: Details of the Audit, Risk and Compliance Committee during the reporting period (2025–26)

Member name	Details
Ms Angela Diamond	Qualifications, knowledge, skills and experience Ms Angela Diamond has held several senior finance positions within the public service and is currently the Chief Financial Officer at Services Australia. Angela has a Bachelor of Commerce from the Australian National University and is a Certified Practising Accountant. Number of meetings attended / total number of meetings eligible 4/4 Total annual remuneration Nil — employed by a Commonwealth entity Additional information Chair and independent member
Mr Glenn Appleyard	Qualifications, knowledge, skills and experience Mr Glenn Appleyard has been a member of the Pricing Authority since 2011. He 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 Chair of the Tasmanian Economic Regulator. Number of meetings attended / total number of meetings eligible 2/3 Total annual remuneration Nil — Pricing Authority member Additional information Pricing Authority member

Member name	Details
Distinguished Prof Jane Hall AO	Qualifications, knowledge, skills and experience Professor Jane Hall AO is a Distinguished Professor of Health Economics at the University of Technology Sydney. She received the National Health and Medical Research Council Outstanding Contribution Award in 2017. She was named as one of the Australian Financial Review/Westpac 100 Women of Influence in 2016. Professor Hall is a Fellow of the Academy of Social Sciences in Australia, where she previously served as President, and a Fellow of the Australian Academy of Health and Medical Sciences. She has worked across many areas of health economics. Her current research is focused on funding and financing issues and payment reform. Number of meetings attended / total number of meetings eligible 1/1 Total annual remuneration Nil – Pricing Authority member Additional information Pricing Authority member
Mr John Lenarduzzi	Qualifications, knowledge, skills and experience John Lenarduzzi is the Executive Director of Global and Commercial Operations of CyberCX's Managed Security Services practice. John has over 20 years' experience working in technology and security environments and spent 7 years as a senior executive in Australia's National Intelligence Community. John has a Bachelor of Electrical and Electronic Engineering (Flinders University) and a Master of Business Administration (Deakin). He completed the Senior Executives in National Security Program at Harvard Kennedy School in 2017 and has also served as an independent member on multiple audit, risk and compliance committees. Number of meetings attended / total number of meetings eligible 3/4 Total annual remuneration \$6,720 Additional information Independent member

Member name	Details
Ms Yaso Arumugam	Qualifications, knowledge, skills and experience Ms Arumugam has extensive experience working as a senior executive public servant and in the private sector leading agencies, leading transformational digital, data and cyber security programs, policies and strategies. She currently works for Bluerydge as a Senior Cyber Security Consultant and Career Manager. Ms Arumugam also works for the Department of Finance as an Independent Assurance Review team member. She has participated in a number of assurance activities to support Senior Responsible Officers of large complex government programs and projects. Ms Arumugam holds a BSc in Electronics Engineering and has completed the Advanced Management and Leadership Program at the University of Oxford. Number of meetings attended / total number of meetings eligible 4/4 Total annual remuneration \$11,200 Additional information Independent member

Risk management

IHACPA’s enterprise-wide approach to risk management remains at the forefront of all our activities. Risk management is embedded in our day-to-day activities and supported by governance arrangements, assurance activities and controls, communication and training, and defined roles and responsibilities. Our risk management policy and framework outlines our commitment to maintaining a positive, transparent and risk-aware culture, and sets out the arrangements for implementing, monitoring, reviewing and continuously improving risk management across the organisation.

We manage several types of risks to ensure a consistent and comprehensive understanding of uncertainty across the organisation. These risk types support clear identification, assessment and reporting across enterprise, program and project activities. **Table 7** outlines our risk categories.

Table 7: IHACPA’s risk categories

Risk	Description
Artificial Intelligence (AI) risk	Risks arising from the use of AI could affect IHACPA’s decision-making, data integrity, privacy, security and fairness. Poorly governed AI may introduce errors or bias into analysis, expose personal or sensitive information, or create transparency and accountability issues. We manage AI risk by assigning accountable owners and maintaining an internal AI use-case register, requiring risk assessments before procurement or change.
Enterprise risks	Enterprise risks are high-level risks that could materially impact IHACPA’s ability to deliver its purpose, legislative functions or strategic priorities. Enterprise risks are monitored by the Executive and reviewed by ARCC. We have identified 4 key enterprise-level risk categories: 1. reputational risks 2. data and information governance risks 3. corporate and operational risks 4. innovation risks.

Risk	Description
Program and project risks	Program and project risks relate to uncertainties that may affect the delivery, continuity, scope, quality, timelines, resources or budget of IHACPA’s ongoing programs and time-limited initiatives. These risks may arise from changes in government priorities, data availability, stakeholder expectations, sector reforms or funding pressures. Effective management of program and project risks remain aligned with our organisational objectives, with risks monitored at the relevant division or project level and escalated when they have broader implications for our strategic priorities or operations.
Shared risks	Shared risks are those that relate to IHACPA’s responsibilities and objectives but extend beyond its direct control, requiring coordinated oversight with other agencies. We identify and manage these risks through engagement with the National Health Funding Body, the Department of Health, Disability and Ageing and other national bodies via shared risk registers and established committees, working groups and forums. Clear roles, coordinated decision-making, timely information sharing and joint monitoring support effective risk management.
Innovative and emerging risks	Emerging risks are developing or uncertain risks that may impact IHACPA in the future but are not yet sufficiently defined for inclusion in the main risk register. These may arise from innovative activities where the consequences are not yet known, and where we maintain a higher tolerance for experimentation. Emerging risks will be captured in the risk library.

Additionally, we maintain a shared strategic risk register with the National Health Funding Body and other national bodies. This register identifies joint risks that the agencies manage together. The current risks are:

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

We are also developing a joint risk register with the Department of Health, Disability and Ageing in relation to our accommodation functions.

We have a comprehensive risk management process that outlines how risks are identified, analysed, assessed, evaluated, treated, monitored and reviewed. We also use a risk assessment template, including a risk assessment matrix, to ensure a consistent approach to risk analysis.

Compliance

IHACPA has a broad range of compliance obligations. These include key statutory obligations set out in the NHR Act, *Aged Care Act 2024*, National Health Reform Agreement, *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and Public Governance, Performance and Accountability Rule 2014 (PGPA Rule).

Other legal and compliance obligations include work health and safety, intellectual property, public interest disclosure, the protective security policy framework, website accessibility and records management.

As the accountable authority, our CEO receives management assurances on our compliance with these obligations through an organised system of controls and special exercises. These include substantive testing, monthly reports, exception notifications and compliance audits undertaken by an independent internal auditor and reviewed by ARCC.

We also have a compliance obligation that all staff complete essential eLearning training on these obligations on commencement and annually thereafter.

Assurance

IHACPA's internal audit program in 2025–26 supported compliance and provided assurance on our key delivery objectives and effectiveness of our control frameworks.

Our information and communication technology systems were independently assessed as meeting relevant standards.

During the 2025–26 financial year, no compliance issues arose from our administration of relevant sections of the NHR Act.

Procurement performance

We have reviewed our internal procurement policies to ensure they align with the Commonwealth Procurement Rules.

We were compliant with the Commonwealth Procurement Rules during the financial year.

Significant non-compliance issues with finance law

In 2025–26, we made no reports to the Minister for Health and Ageing of significant non-compliance with finance law under section 19 of the PGPA Act.

Financial authorisation

As a corporate Commonwealth agency, IHACPA adheres to the PGPA Act and the PGPA Rule and is subject to the Commonwealth Procurement Rules. Line managers have value and purchase class limits in accordance with financial delegations approved and regularly reviewed by the accountable authority.

Fraud and corruption control plan

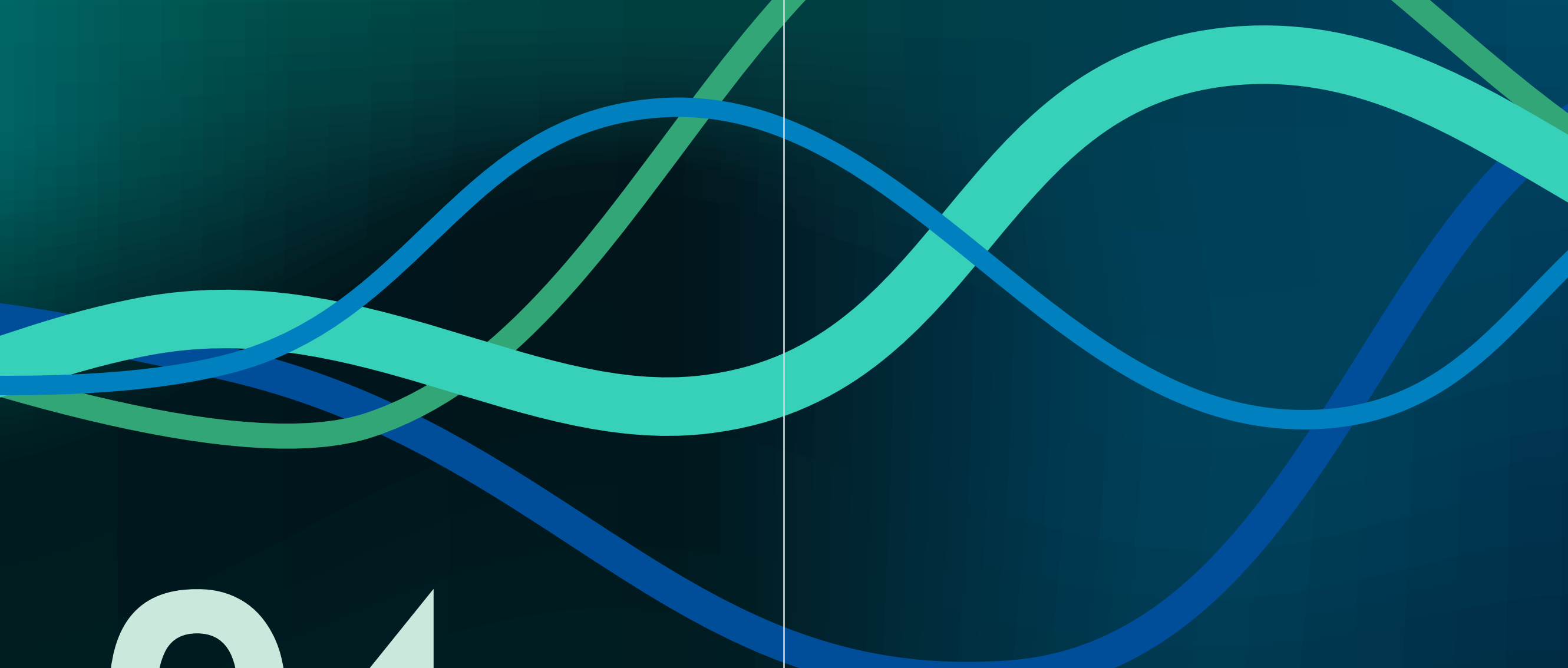
IHACPA's fraud and corruption control plan is a critical internal tool to mitigate unauthorised use of our data and financial resources and its impacts. The plan supports our CEO as the accountable authority to meet legislative obligations under the Fraud and Corruption Rule (section 10 of the Public Governance, Performance and Accountability Rule 2014). The plan sets out our strategic and operational approach to identifying, preventing, detecting and responding to fraud and corruption across the organisation, and supports understanding of current and emerging threats. This approach is supported by policies, procedures and practices that align with the Commonwealth Fraud and Corruption Control Framework and other best practices.

We routinely monitor both internal and external factors that may influence or shift our fraud and corruption risk profile. To support this, we maintain a fraud and corruption risk register which documents 6 enterprise level fraud and corruption risks and their controls and mitigation strategies.

Staff are required to undertake fraud and corruption awareness training on commencement and annually thereafter.

Inter-agency financial activity

During the 2025–26 financial year, IHACPA received shared services resourcing from the department. The department charged \$1,130,000 to provide these services, which included treasury, financial transaction processing, information and communication technology desktop services and parliamentary support.



04

Annual performance statements

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4.1 Introductory statement

I, Professor Michael Pervan, as the accountable authority of the Independent Health and Aged Care Pricing Authority (IHACPA), present the 2025–26 annual performance statements of IHACPA, 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 sub-section 39(2) of the PGPA Act (section 16F of the PGPA Rule).

4.2 Performance in 2025–26 – Portfolio Budget Statements

In 2025–26, we achieved our deliverables in line with the Health and Aged Care Portfolio Budget Statements 2025–26 and the IHACPA Work Program and Corporate Plan 2025–26.

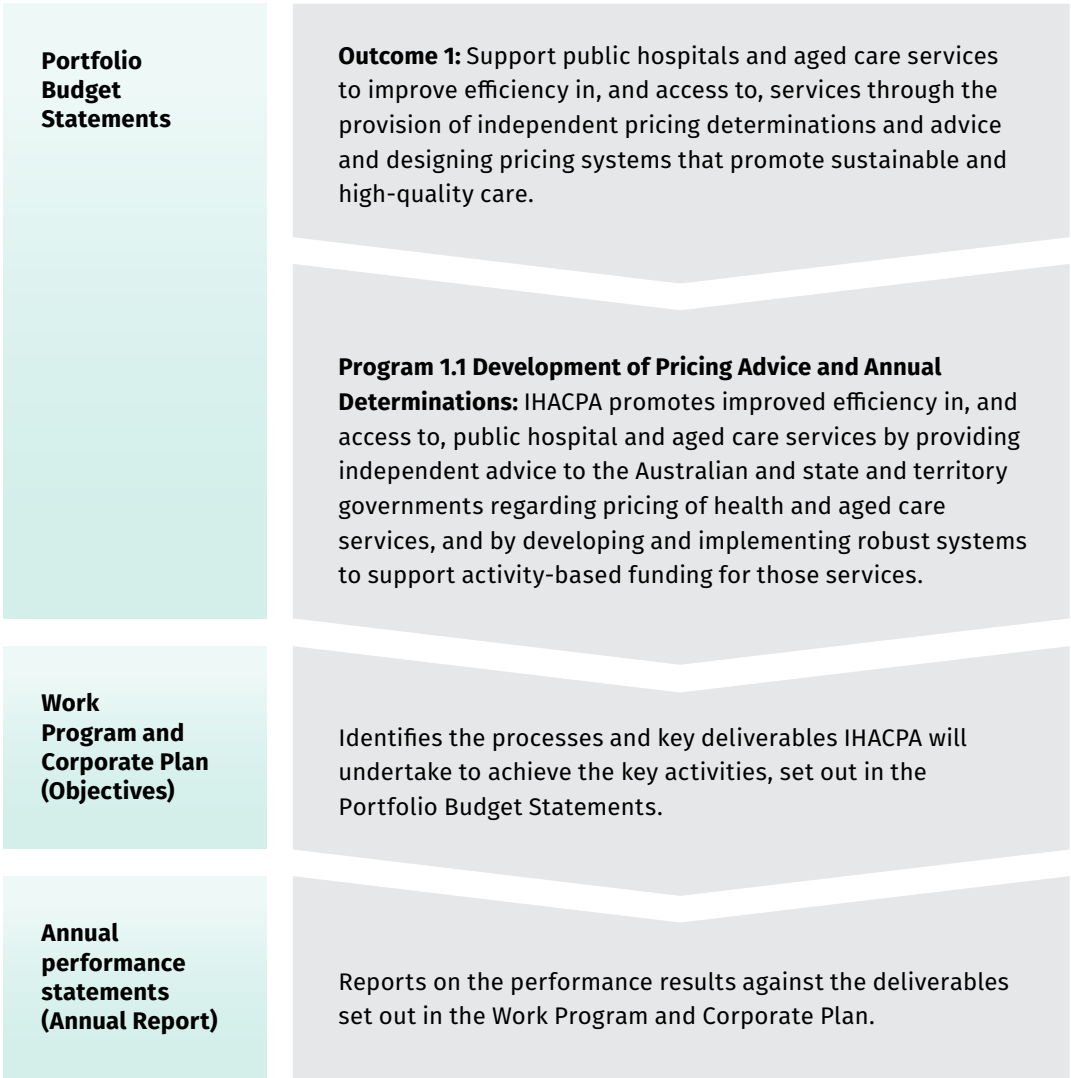
The Portfolio Budget Statements provide performance information for programs of work undertaken by Commonwealth entities for 2025–26.

Under the PGPA Act and PGPA Rule, we are required to publish a 4-year corporate plan that defines our purpose, key activities and operating context, as well as our work set out in the Portfolio Budget Statements. In 2026, following a review that identified opportunities to strengthen alignment, improve consistency, better meet the PGPA requirements and Department of Finance best practice guidelines, we separated our corporate plan from the work program.

Our work program outlines the agency’s key activities under the NHR Act. It has been developed in consultation with government, health and aged care sector stakeholders.

The relationships between the Portfolio Budget Statements, corporate plan and annual performance statements for 2025–26 is displayed in **Figure 6**.

Figure 6: Relationship between IHACPA's Portfolio Budget Statements, work program and corporate plan and annual performance statements



4.3 Strategic objective one: Perform pricing functions

IHACPA's primary functions are to determine the national efficient price (NEP) and the national efficient cost (NEC) for Australian public hospital services and provide annual pricing advice for aged care services to the Australian Government. Detailed information about the methodology used to develop IHACPA's pricing determinations, pricing advice and their underpinning policy basis is published on our [website](#).

Public hospital services

To support the refinement of the NEP and NEC determinations, and the development and refinement of the national activity-based funding (ABF) system for public hospital services, we held public consultations to encourage feedback from the health care sector and the community. The outcomes of the public consultations informed the development of the [Pricing Framework for Australian Public Hospital Services 2026–27](#), which was published on 4 December 2025. The pricing framework includes IHACPA's policy basis, principles and scope for the [NEP Determination 2026–27](#) (NEP26) and [NEC Determination 2026–27](#) (NEC26). On 11 March 2026, the determinations were provided to all health ministers and published on our website.

Following 4 years of shadow pricing, community mental health transitioned to ABF and has been priced using the Australian Mental Health Care Classification Version 1.1 since 1 July 2025.

The Addendum to the National Health Reform Agreement 2026–31 (NHRA) specified a range of updates and changes to the calculation of Australian Government funding for 2026–27 and beyond. We have begun this process and will continue to align to the new NHRA as requisite reviews and consultations are completed.

Residential aged care

IHACPA is responsible for providing residential aged care and residential respite care pricing and costing advice. This informs government decisions on the Australian National Aged Care Classification (AN-ACC) funding model and, where requested, other related elements of residential aged care pricing and costing.

In July 2025, we provided the [Residential Aged Care Pricing Advice 2025–26](#) to the Minister for Health and Ageing. This marked our third year of delivering pricing advice for residential aged care and residential respite care. The advice was developed using cost data from the Residential Aged Care Cost Collection 2024 and considered input from aged care stakeholders through public consultation. The pricing advice included:

- » the recommended AN-ACC price
- » recommended adjustments to the AN-ACC funding model, including price weights for each AN-ACC class, respite class and base care tariff category
- » the estimated gap between the costs of delivering required hotel services and specific types of revenue received by residential aged care services.

In April 2026, we published the [Pricing Framework for Australian Residential Aged Care Services 2026–27](#), which was developed based on stakeholder feedback to our public consultation. This work will inform the development of the Residential Aged Care Pricing Advice 2026–27, to be provided to the minister in July 2026.

Everyday living services

Registered providers of residential aged care receive a hotelling supplement to support the delivery of everyday living services, as outlined in the Aged Care Rules 2025. Government has requested our advice on the cost differentials, including the impact of geographic location and the complexity of resident care needs by 1 July 2028. IHACPA will undertake analysis and advice through a multi-year program of work. Government will make a policy decision as to whether required hotel services could be funded using a different approach.

The Multi-Purpose Services Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program

The Multi-Purpose Services Program (MPSP) provides integrated health and aged care services for rural and remote communities nationally, in areas that cannot support standalone aged care and health services.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP) provides aged care services to older Aboriginal and Torres Strait Islander peoples. These aged care services are mainly delivered in rural and remote areas nationally.

The MPSP Funding Model Assessment – Final Report was released in June 2026, following the first and second reports delivered to the government and department in November 2025 and March 2026, respectively. The final report presents comprehensive qualitative and quantitative analysis, along with final recommendations on potential future funding arrangements for the MPSP and associated implementation considerations.

Informed by our analysis and recommendations, the government will determine whether to implement any proposed funding changes for the MPSP, including consideration of interim funding model adjustments. Our advice will form part of the government's broader consideration under the MPSP Funding Model Review.

In April 2026, we delivered to the government the NATSIFACP Funding Model Assessment – First Report. This report included the horizon scan, findings from stakeholder engagement and consultation, scoping of existing data sources and initial recommendations to guide the progression of the funding model. The first report outlined recommendations and the scope of work required to progress the project to the next phase.

Refundable accommodation deposits

IHACPA is responsible for assessing applications from registered providers to charge accommodation payment amounts above the maximum amount determined by the minister. This amount is indexed annually in line with the Consumer Price Index (CPI) from 1 July each year. These responsibilities were established under the *Aged Care Act 1997* until October 2025 and from 1 November 2025, are provided under the *Aged Care Rules 2025*.

All decisions made by IHACPA for refundable accommodation deposit (RAD) applications to charge accommodation payments above the threshold must be completed within legislated timeframes.

Our assessment of RADs and extra service fees in 2025–26 is outlined in section 4.9.

Support at Home aged care

The Support at Home program supports older people to remain at home for longer by providing:

- » upfront supports to maintain independence, such as assistive technology and home modifications
- » new classification and budget levels to meet a person's aged care needs
- » participant contributions based on an assessment of income and assets.

The Support at Home program commenced from 1 November 2025 and is being implemented in 2 stages. Existing aged care programs, including the Home Care Packages Program and the Short-Term Restorative Care Programme have been included since 1 November 2025. The Commonwealth Home Support Programme will transition from no earlier than July 2027.

IHACPA is required to provide advice to the minister on unit prices for services on the Support at Home service list.

In March 2026, we released the Consultation Paper on the Pricing Framework for Australian Support at Home Aged Care Services 2027–28. The consultation paper will inform the development of the principles, scope and methodology we use in developing the Support at Home Pricing Advice 2027–28.

In May 2026, we published the Pricing Framework for Australian Support at Home Aged Care Services 2026–27 and the Support at Home Pricing Advice 2026–27.

On 19 May 2026, government announced a pause on introducing price caps to the Support at Home program. The recommended prices in IHACPA's pricing advice do not represent a price cap, benchmark or guidance for aged care providers when setting their prices.

Results

The reporting of key activities in this annual report refers to the deliverables of strategic objective one: Perform pricing functions in the IHACPA Work Program and Corporate Plan 2025–26 and Section 1.1 of the Portfolio Budget Statements 2025–26. A summary of each deliverable and the analysis of our performance against the deliverables is outlined in **Table 8**.

Table 8: Summary of performance for strategic objective one: Perform pricing functions in 2025–26

Deliverables	Timeframe	Outcome	Analysis
1. Complete the public consultation process for the Pricing Framework for Australian Public Hospital Services 2026–27.	July 2025	Delivered	The Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2026–27 was released for public consultation on 14 May 2025 and closed on 13 June 2025.
2. Provide the draft Pricing Framework for Australian Public Hospital Services 2026–27 to health ministers for a 45-day comment period.	September 2025	Delivered	The draft Pricing Framework for Australian Public Hospital Services 2026–27 was released to health ministers on 9 September 2025.
3. Publish the final Pricing Framework for Australian Public Hospital Services 2026–27 on the IHACPA website.	December 2025	Delivered	The final Pricing Framework for Australian Public Hospital Services 2025–26 was published on 3 December 2025.
4. Finalise decisions on the General List of In-Scope Public Hospital Services for additional or altered in-scope services for 2026–27.	December 2025	Delivered	We assessed requests for in-scope public hospital services as per the annual General List of In-Scope Public Hospital Services process. The outcome was published in the draft NEP26 and released to health ministers on 4 December 2025.
5. Finalise decisions on legitimate and unavoidable cost variations to determine whether adjustments are required for the NEP26.	December 2025	Delivered	We assessed requests for adjustments to the national pricing model and the outcome was published in the draft NEP26 and released to health ministers on 4 December 2025.
6. Provide the draft NEP26 and NEC26 to health ministers for a 45-day comment period.	December 2025	Delivered	The draft NEP26 and NEC26 was provided to health ministers for comment under Section 211 of the <i>National Health Reform Act 2011</i> on 28 November 2025.
7. Publish the NEP26 and NEC26 on the IHACPA website.	March 2026	Delivered	The NEP26 and NEC26 was published on 11 March 2026.

Deliverables	Timeframe	Outcome	Analysis
8. Incorporate safety and quality reforms into the pricing and funding of public hospital services.	Ongoing	Ongoing	We continue to incorporate approaches for sentinel events, hospital acquired complications and avoidable hospital readmissions into the pricing and funding of public hospital services. During 2025–26, the safety and quality models for hospital acquired complications and avoidable hospital readmissions received technical updates in consultation with clinical and jurisdictional stakeholders, to ensure they remain based on the most contemporary classification data.
9. Provide confidential NEP forecast for future years to jurisdictions.	March 2026	Delivered	The confidential NEP forecast was provided to the Prime Minister, premiers and chief ministers on 27 November 2025.
10. Publish the Supplementary Block Funding Advice to the Administrator of the National Health Funding Pool for 2025–26.	June 2026	Delivered	The Supplementary Block Funding Advice was provided to the Administrator of the National Health Funding Pool 2025–26 and was published on 15 June 2026.
11. Continue to investigate options for refining the intensive care unit adjustment.	March 2026	Ongoing	IHACPA will prioritise the investigation of options for refining the intensive care unit adjustment based on feedback received during the consultation process.
12. Continue to investigate alternative methodologies to calculate the Indigenous adjustment.	Ongoing	Ongoing	IHACPA will prioritise the investigation of options for refining the Indigenous adjustment based on feedback received during the consultation process.

Deliverables	Timeframe	Outcome	Analysis
13. Consider the implications of the review of the funding methodology for unqualified newborns.	December 2025	Ongoing	Preliminary analysis has not indicated a clear evidence base to change the funding methodology for unqualified newborns in the short-term. IHACPA is undertaking further analysis to identify any policy basis and data requirements to support any longer-term changes and will continue to consult with its advisory committees on this work.
14. Review the appropriateness of price harmonisation of admitted and non-admitted chemotherapy and dialysis.	July 2025	Ongoing	We are continuing work to investigate approaches for price harmonisation between admitted and non-admitted care as part of NEP27.
15. Publish the final Pricing Framework for Australian Residential Aged Care Services 2025–26 on the IHACPA website.	By July 2025	Delivered	The Pricing Framework for Australian Residential Aged Care Services 2025–26 was published on 28 May 2025.
16. Complete the public consultation process for the Pricing Framework for Australian Residential Aged Care Services 2026–27.	September 2025	Delivered	The Consultation Paper on the Pricing Framework for Australian Residential Aged Care Services 2026–27 was released for public consultation on 10 July 2025 and closed on 22 August 2025.
17. Publish the final Pricing Framework for Australian Residential Aged Care Services 2026–27 on the IHACPA website.	By July 2026	Delivered	The Pricing Framework for Australian Residential Aged Care Services 2026–27 was published on 13 April 2026.
18. Undertake a feasibility study and provide advice to government decisions on funding for everyday living services, previously known as hotel services.	Ongoing	Ongoing	Government is seeking our advice on the cost differentials to provide everyday living services, considering the impact of geographic location and the complexity of resident care needs. Government will make a policy decision using our analysis and advice.

Deliverables	Timeframe	Outcome	Analysis
19. Undertake an assessment and provide advice to inform government decisions on the funding model for MPSP.	June 2026	Delivered	The MPSP Funding Model Assessment – Final Report was provided to the minister on 15 May 2026.
20. Undertake an assessment and provide advice to inform government decisions on the funding model NATSIFACP.	Ongoing	Ongoing	The government requested we undertake a funding model assessment for the NATSIFAC program through a multi-year program of work. This is being done in collaboration with the department and includes consultation with providers, and detailed qualitative and quantitative analysis.
21. Complete the public consultation process for the pricing approach for the Support at Home service list 2026–27.	August 2025	Delivered	The Consultation Paper on the Pricing Framework for Australian Support at Home Aged Care Services 2026–27 was released for public consultation on 11 June 2025 and closed on 18 July 2025.
22. Publish the final Pricing Framework for the Australian Support at Home Aged Care Services 2026–27 on the IHACPA website.	By July 2026	Delivered	The Pricing Framework for Australian Support at Home Aged Care Services 2026–27 was published on 28 May 2026.
23. Provide pricing advice to inform Australian Government decisions on the Support at Home service list for 2026–27.	By July 2026	Delivered	The Support at Home Pricing Advice 2026–27 was provided to the minister and the department on 27 November 2025.
24. Assess applications to charge accommodation payment amounts above the minister's maximum.	Ongoing	Ongoing	We continue to assess applications to charge accommodation payment amounts above the amounts prescribed under the Aged Care Rules 2025.
25. Provide advice, as requested, to the department to support the Prescribed List reforms.	Ongoing	Ongoing	We continue to work with the department and key stakeholders to support further reforms to the list.

4.4 Strategic objective two: Refine and develop hospital and aged care classification systems

Public hospital services

Classifications provide a nationally consistent method for grouping patients, treatments and associated costs. They support the management, measurement and funding of high-quality and efficient health care services.

IHACPA develops the national classification systems for admitted acute care, admitted subacute and non-acute care, emergency care, non-admitted patient care, mental health care, and teaching and training services. These classifications are reviewed regularly and updated periodically. This ensures episodes of care are grouped into clinically coherent categories with similar costs. Refinement is informed by robust statistical analysis and consultation with clinical, technical and other key stakeholders.

Admitted acute care

The AR-DRG classification is used to price admitted acute patient services. AR-DRGs are underpinned by the classifications and standards used to collect admitted care activity data:

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

These are collectively known as ICD-10-AM/ACHI/ACS.

In April 2025, we released ICD-10-AM/ACHI/ACS Thirteenth Edition, which was implemented on 1 July 2025 following a 3-year refinement and development process. Key changes included:

- » implementation of cluster coding using a diagnosis cluster identifier to indicate the relationship between codes
- » a major review of the ACS to streamline the standards, reduce ambiguity and apply a standardised format
- » review of procedural complications
- » addition of codes for new or missing concepts, including use of vaping devices and voluntary assisted dying
- » further refinements to the classification of social factors
- » revised classifications for organ donation, procurement and transplantation.

In July 2025, we released AR-DRG Version 12.0. The new version includes guiding principles to support consistent grouping of intervention-based episodes of care, a major review of Adjacent Diagnosis Related Groups (ADRG) within Major Diagnostic Category 14 *Pregnancy, Childbirth and the Puerperium* and a new ADRG for posthumous organ procurement.

Emergency care

The Australian Emergency Care Classification (AECC) Version 1.1 was released in August 2024 and was used to price emergency department activities from 1 July 2025. We developed the AECC Version 1.1 through detailed statistical analysis of national public hospital activity and cost data. It included a recalibration of the complexity model based on the most recent activity and cost data. We commenced development of the AECC Version 2.0 in 2025. This work includes a review of paediatric patients presenting in emergency care and standard refinements, such as:

- » recalibration of the complexity model using recent cost and activity data
- » incorporation of new editions of ICD-10-AM and EPD Short List
- » review and refinement of the Emergency Care Diagnosis Groups that are used for assigning the AECC end classes.

Subacute and non-acute care

The Australian National Subacute and Non-Acute Patient Classification (AN-SNAP) Version 5.0 was released in December 2021 and has been used to price subacute and non-acute services since 1 July 2024. We are investigating several areas for refinement, including a review of the Frailty Related Index of Comorbidities and patients impacted by delayed discharge of an older person. This work will be progressed through the Subacute Care Working Group.

Non-admitted care

The Tier 2 Non-Admitted Services Classification (Tier 2) is the existing classification system used to price non-admitted patient services. From July 2025, Tier 2 Version 9.1 was implemented and used to price non-admitted care.

We commenced the Australian Non-Admitted Patient Classification Project (ANAPP) in 2023. The ANAPP is a key initiative led by IHACPA to replace the Tier 2 Classification. The ANAPP is comprised of 4 stages. With the first stage of the project now complete, we commenced the Stage 2 Pilot in late 2023. The pilot will utilise existing clinical, operational and cost data obtained from participating hospital electronic medical record systems and other relevant information systems to develop a comprehensive activity and costed dataset to inform a new non-admitted classification.

Mental health care

We released the Australian Mental Health Care Classification (AMHCC) Version 1.1 in December 2023, which has been used to price admitted and community mental health care since 1 July 2025. In 2024, we commenced development of AMHCC Version 2.0 and are investigating areas for refinement. These include the treatment of age within the classification, reviewing consumer characteristics of same-day treatments and the application of mental health legal status across settings. We are completing these investigations in consultation with jurisdictions, clinical and consumer representatives and other stakeholders.

Teaching and training

The Australian Teaching and Training Classification (ATTC) Version 1.0 was released in July 2018. It aims to provide a nationally consistent approach to how teaching and training activities are classified, counted and costed. In 2025–26, we worked with jurisdictions to gain a clearer understanding of the composition of existing block-funded amounts for teaching and training, and how this is distributed across the states and territories. This occurred while improvements to the reporting of activity and cost data continue to be made to support implementation.

ICD-11 Implementation

In 2025–26, we progressed work to support Australia's potential transition to the International Classification of Diseases, Eleventh Revision (ICD-11). This work was guided by IHACPA's framework for a decision to implement ICD-11. The framework considers ICD-11 maturity, classification architecture, stakeholder engagement, governance and how ICD-11 could be used across our broader classification suite.

A central focus was the continued development and refinement of the case for replacement of ICD-10-AM with ICD-11, including cost-benefit analysis and assessment of system, workforce and implementation impacts. Structured, targeted consultation with jurisdictions and key stakeholders helped to test key assumptions, ensuring that risks, dependencies and potential benefits are clearly articulated and evidence-based.

Broader stakeholder engagement included the release of The Future of IHACPA Classifications consultation paper in October 2025. The paper sought feedback on our ICD-11 framework and broader classification modernisation priorities. This includes the future role of ICD-10 AM, ICD-11 readiness and maturity, cluster coding, national classification needs, and the potential implications for AR-DRGs, ABF classifications, and IHACPA's wider classification suite.

At the same time, we advanced work on classification architecture and digital readiness through the Classification Modernisation Project. In December 2025, work on this project commenced by developing a summary of requirements to inform future system capability, reduce reliance on manual processes, support digital classification outputs, and identify functionality required for an ICD-11-compatible platform.

Together, these activities are providing the evidence base and planning foundations for informed decision-making on ICD-11 in Australia. They are also supporting a clearer understanding of the costs, benefits, risks, dependencies and implementation considerations associated with any future transition.

Aged care services

Within the residential aged care sector, the AN-ACC funding model provides approved aged care providers with subsidies at a level that reflects service location, specialisation and each resident's care needs. The AN-ACC funding model relates resident care need characteristics to the resources required to deliver their care. The refinement of AN-ACC classes and branching structure is the responsibility of the department. Where requested by government, we may recommend evidence-based areas of refinement to the classification system utilised by the AN-ACC funding model.

Results

The reporting of key activities in this annual report refers to the deliverables of strategic objective two: Refine and develop hospital and aged care activity classification systems in the IHACPA Work Program and Corporate Plan 2025–26 and Section 1.1 of the Portfolio Budget Statements 2025–26. A summary of each deliverable and the analysis of our performance against the deliverables is outlined in **Table 9**.

Table 9: Summary of performance for strategic objective two: Refine and develop hospital and aged care activity classification systems in 2025–26

Deliverables	Timeframe	Outcome	Analysis
1. Implement ICD10-AM/ACHI/ACS Thirteenth Edition.	July 2025	Delivered	We released ICD10-AM/ACHI/ACS Thirteenth Edition in April 2025 for implementation from 1 July 2025.
2. Release AR-DRG Version 12.0.	July 2025	Delivered	We released AR-DRG Version 12.0 in July 2025 for implementation from 1 July 2026.
3. Refine AN-SNAP.	Ongoing	Ongoing	In 2025–26, we continued exploring a range of refinement areas for AN-SNAP based on stakeholder feedback or identified from the analysis of recent data sets. We will continue to explore further refinements through our working groups and advisory committees.
4. Continue the development of AECC Version 2.0.	Ongoing	Ongoing	We will continue the development of the AECC Version 2.0 in 2025–26.
5. Implement the EPD Short List (ICD-10-AM Thirteenth Edition).	July 2025	Delivered	We released the EPD Short List (ICD-10-AM Thirteenth Edition) in May 2025 for implementation from 1 July 2025. This coincides with the implementation of ICD-10-AM Thirteenth Edition.
6. Continue to refine the Tier 2 Non-Admitted Services Classification.	Ongoing	Ongoing	As it transitions to a 3-year development cycle, we will continue to explore further refinements to Tier 2 through our working groups and advisory committees.
7. Continue the multi-stage project to support the development of a new patient level non-admitted care classification.	Ongoing	Ongoing	ANAPP commenced in 2023 to develop a new non-admitted care classification. As part of 4 stages, we have completed the first stage and commenced the Stage 2 Pilot in November 2023. The pilot is due for completion by early 2027.
8. Continue development of AMHCC Version 2.0.	Ongoing	Ongoing	In 2024, we commenced development of AMHCC Version 2.0 and are investigating areas for refinement.

Deliverables	Timeframe	Outcome	Analysis
9. Continue to work with jurisdictions to implement ATTC.	Ongoing	Ongoing	In 2025–26, we continued to work with jurisdictions to gain a clearer understanding of the composition of existing block-funded amounts for teaching and training, and how this funding is distributed across the states and territories.
10. Manage the international sales of ICD-10-AM/ACHI/ACS and AR-DRG Classification Systems.	Ongoing	Ongoing	We continue to publish products for the ICD-10-AM/ACHI/ACS and AR-DRG classifications that are sold internationally.
11. Make recommendations on refinements to the AN-ACC.	Ongoing	Ongoing	We will continue to provide advice to government on recommended refinements to the classification. We will do this in consultation with our advisory committees and working groups, where requested.

4.5 Strategic objective three: Refine and improve hospital and aged care costing

Costing focuses on the cost and mix of resources used to deliver care and plays a vital role in benchmarking, classification and price development.

Public hospital services

A key component for IHACPA is to coordinate the annual National Hospital Cost Data Collection (NHCDC). NHCDC plays a vital role in ABF as one of the primary inputs into the determination of the NEP. It also informs the development and refinement of ABF classification systems.

To support a consistent and robust NHCDC, we have developed the Australian Hospital Patient Costing Standards (AHPCS), which provide nationally standardised guidance for hospital costing. We continue to refine these standards to support the accurate allocation of in-scope costs to hospital activity and reflect resource utilisation appropriately.

In January 2026, the 2023–24 Independent Financial Review of the NHCDC was published on our website. This covers a review of costing processes and the reconciliation between financial and costing systems. It also covers assessment of the consistency between jurisdictions in the application of the AHPCS version 4.2. For the 2023–24 review, the focus was on costing methodologies and processes within Intensive Care Units (ICUs)/Critical Care Services. The review also sought to understand the allocation methods used nationally and identify variations in costs to inform ongoing work into the suitability of ICU pricing adjustments in the NEP.

In June 2026, the NHCDC Public Sector Report 2023–24 was published on our website. The report presents an overview of hospital cost and activity data, including analysis of trends, cost drivers and nationally consistent cost weights by activity stream.

Aged care services

We conduct regular cost collections to underpin the evidence base we use in delivering residential and Support at Home pricing advice to government.

The Australian Aged Care Costing Standards

We continue to develop costing standards that describe consistent and best practice allocation of costs to aged care residents and participants. These costing standards will be developed for both the residential and Support at Home aged care collections.

Residential aged care cost collection

We collect data from residential aged care services to support evidence-based pricing advice. This helps us understand the costs and activity involved in residential care and supports future AN-ACC pricing and classification refinement advice. Cost collections are a resident-level study of care delivery in providing residential services. This helps ensure our advice reflects the variation of care requirements and sector costs.

The Residential Aged Care Cost Collection 2024–25 involved collecting cost and activity data across 199 residential aged care homes. The report provides a robust costed dataset to inform IHACPA’s Residential Aged Care Pricing Advice 2026–27.

Support at Home cost collection

We conduct regular cost collections for the Support at Home program. The results and findings from the cost collection form one of the key data sets that underpin our pricing advice and support future costing studies. Based on government guidelines, we have only collected data for Home Care Packages (HCP) and Short-Term Restorative Care (STRC) programs. The Commonwealth Home Support Program will be considered in future collections.

The Support at Home Cost Collection 2025 focused on capturing 2023–24 branch level cost and activity data across HCP and STRC to produce a robust costed dataset and associated materials on the Support at Home program. Data was collected from 135 operational service branches across 40 providers, covering 35,636 clients. Analysis of total costs and activity by Support at Home service type showed that more than 70% of both reported costs and activity units were attributed to personal care, care management and domestic assistance.

This is the third year we have undertaken a cost collection for Support at Home services. The cost collection builds on the work of previous years and strengthens the evidence base for developing accurate pricing guidance for in-home aged care, based on actual service delivery costs.

Results

The reporting of key activities in this annual report refers to the deliverables of strategic objective three: Refine and improve hospital and aged care costing in the IHACPA Work Program and Corporate Plan 2025–26 and Section 1.1 of the Portfolio Budget Statements 2025–26. A summary of each deliverable and the analysis of our performance against the deliverables is outlined in **Table 10**.

Table 10: Summary of performance for strategic objective three: Refine and improve hospital and aged care costing in 2025–26

Deliverables	Timeframe	Outcome	Analysis
1. Promote ongoing improvement and consistency in cost data submissions through refinement of the AHPCS, business rules and costing guidelines.	Ongoing	Ongoing	We continued to update the AHPCS through consultation with jurisdictions to identify and prioritise target areas for review.
2. Release the 2023–24 NHCDC Public Sector Report.	February 2026	Delivered	The NHCDC Public Sector Report 2023–24 presents a summary of the public hospital data gathered for the 2023–24 financial year. We received NHCDC data that included 48.2 million in-scope encounters, which is a 9% increase compared to 2022–23.
3. Release the 2023–24 NHCDC Private Sector Report.	February 2026	Delivered	The NHCDC Private Sector Report 2023–24 presents a summary of the admitted acute care data gathered for the 2023–24 financial year and represents 74.9% of private hospital activity.
4. Collect the 2024–25 NHCDC for public and private hospitals.	June 2026	Delivered	We continued to collect and analyse the NHCDC for public and private hospitals.
5. Release the independent financial review report of the 2023–24 NHCDC.	February 2026	Delivered	To ensure that the quality of the NHCDC is robust and fit-for-purpose, we commissioned an independent financial review to assess whether all participating hospitals have included appropriate costs and patient activity.

Deliverables	Timeframe	Outcome	Analysis
6. Investigate phasing out the private patient correction factor.	Ongoing	Ongoing	The private patient correction factor was introduced as an interim solution for the issue of missing private patient costs in the NHCDC. In 2025–26, we continued to evaluate the private patient correction factor and remove it where appropriate.
7. Collect residential aged care cost collection 2024–25 data.	December 2025	Delivered	To inform the development and refinement of the AN-ACC funding model, we conducted annual cost collection in the residential aged care setting.
8. Collect Support at Home cost collection 2025 data.	December 2025	Delivered	To inform the development of pricing advice for the Support at Home service list, we have commenced a Support at Home Cost collection. The results and findings from this cost collection will feed into the development of a costing framework, costing methodology and data sets. This will support the development of our pricing advice.
9. Release the Residential Aged Care Cost Collection 2024–25 Report.	April 2026	Delivered	The Residential Aged Care Cost Collection 2024–25 Report was provided to the minister in April 2026 following the completion of data collection.
10. Release the Support at Home Cost Collection 2025 Report.	April 2026	Delivered	The Support at Home Cost Collection 2025 Report was provided to the minister in April 2026 following the completion of data collection.
11. Continue the development of the Australian Aged Care Costing Standards.	June 2026	Ongoing	We continue to develop costing standards that describe consistent and best practice allocation of costs to aged care residents and participants.
12. Undertake focused studies on costs associated with identified priority areas, which may be resident or facility related, found through consultation processes.	June 2026	Delivered	We have placed focus on priority areas within our 2025 cost collections. We will continue to identify and collect costs from priority areas as part of our annual cost collections.

4.6 Strategic objective four: Determine data requirements and collect data

Timely, accurate and reliable data is vital for IHACPA to undertake our work functions.

Throughout 2025–26, we continued to work with jurisdictions and national bodies, ensuring cost and activity data was received in a timely manner and adhered to data standards.

We achieve this through the rolling Three Year Data Plan 2026–27 to 2028–29 that was published in June 2026. The plan specifies the data requirements and timelines that we will use to collect data. It also includes reporting commitments from the Australian Government, and state and territory governments, such as information about the aged care data that we need to collect to provide our pricing and costing advice.

Results

The reporting of key activities in this annual report refers to the deliverables of strategic objective four: Determine data requirements and collect data in the IHACPA Work Program and Corporate Plan 2025–26, and Section 1.1 of the Portfolio Budget Statements 2025–26. A summary of each deliverable and the analysis of our performance against the deliverables is outlined in **Table 11**.

Table 11: Summary of performance for strategic objective four: Determine data requirements and collect data in 2025–26

Deliverables	Timeframe	Outcome	Analysis
1. Publish the Three Year Data Plan 2026–27 to 2028–29.	June 2026	Delivered	The Three Year Data Plan was published in June 2026.
2. Complete the annual review of ABF national best endeavours data sets and national minimum data sets.	December 2025	Delivered	The national best endeavours data sets and the national minimum data sets for the 2025–26 reporting period were finalised in December 2025 and published in January 2026.

Deliverables	Timeframe	Outcome	Analysis
3. Implement diagnosis cluster identifier (DCID) into admitted patient care datasets.	July 2025	Delivered	We consulted with state and territory governments and key stakeholders to implement the DCID into the admitted patient care national minimum data set for 2025–26.
4. Further develop the Secure Data Management System functionality.	Ongoing	Ongoing	We will continue to develop the Secure Data Management System to support our core technical functions.
5. Maintain the security of the Secure Data Management System.	Ongoing	Ongoing	We will continue to maintain security of the Secure Data Management System by ensuring that current government requirements related to data security are implemented.
6. Collect jurisdictional submissions for June quarter 2025 ABF activity data.	September 2025	Delivered	We collected ABF activity data for June quarter 2025 in line with the Three Year Data Plan 2025–26 to 2027–28.
7. Collect jurisdictional submissions for September quarter 2025 ABF activity data.	December 2025	Delivered	We collected ABF activity data for September quarter 2025 in line with the Three Year Data Plan 2025–26 to 2027–28.
8. Collect jurisdictional submissions for December quarter 2025 ABF activity data.	March 2026	Delivered	We collected ABF activity data for December quarter 2025 in line with the Three Year Data Plan 2025–26 to 2027–28.
9. Publish data compliance report for March quarter 2025.	September 2025	Delivered	Data compliance reports were published for the March quarter 2025 in September 2025.
10. Publish data compliance report for June quarter 2025.	December 2025	Delivered	Data compliance reports were published for the June quarter 2025 in December 2025.
11. Publish data compliance report for September quarter 2025.	March 2026	Delivered	Data compliance reports were published for the September quarter 2025 in March 2026.
12. Publish data compliance report for December quarter 2025.	June 2026	Delivered	Data compliance reports were published for the December quarter 2025 in June 2026.

Deliverables	Timeframe	Outcome	Analysis
13. Release the Data Quality Framework.	August 2025	Delivered	In October 2025, we published our Data Quality Framework.
14. Continue to promote access to data through the National Benchmarking Portal (NBP).	Ongoing	Ongoing	In 2025–26, we updated the existing dashboards to include data for 2022–23. We will continue to work with jurisdictions and key stakeholders to enhance the functionality of datasets available through the NBP.

4.7 Strategic objective five: Investigate and make recommendations concerning cost-shifting and cross-border disputes between states and territories in relation to public hospitals

Under the NHR Act, we may be required to investigate and make recommendations on cross-border disputes between states and territories and assess cost-shifting disputes. During 2025–26, we did not receive any cost-shifting or cross-border disputes.

The Cost-Shifting and Cross Border Dispute Resolution Policy is reviewed regularly, in consultation with all jurisdictions, to ensure it remains current and fit-for-purpose in supporting our role.

Results

The reporting of key activities in this annual report refers to the deliverables of strategic objective five: Investigate and make recommendations concerning cost-shifting and cross-border disputes in the IHACPA Work Program and Corporate Plan 2025–26 and Section 1.1 of the Portfolio Budget Statements 2025–26. A summary of each deliverable and the analysis of our performance against the deliverables is outlined in **Table 12**.

Table 12: Summary of performance for strategic objective five: Investigate and make recommendations concerning cost-shifting and cross-border disputes in 2025–26

Deliverables	Timeframe	Outcome	Analysis
1. Investigate and make recommendations on cross-border disputes.	Ongoing	Not required	We did not receive submissions to investigate cross-border disputes in 2025–26.
2. Investigate and make an assessment on cost-shifting disputes.	Ongoing	Not required	We did not receive submissions to investigate cost-shifting disputes in 2025–26.

4.8 Strategic objective six: Conduct independent and transparent decision-making and engage with stakeholders

We conduct our work independently, which allows the agency to deliver impartial, evidence-based decisions and advice. IHACPA is also transparent in our decision-making processes. We consult extensively with the Australian Government, state and territory governments, the health and aged care sectors, and other stakeholders, to inform the methodology that underpins our work.

Through ongoing stakeholder engagement, including input from our advisory committees and working groups, we can draw on an extensive range of expertise in undertaking our functions. This ensures our work is informed by expert advice and maintains credibility across the care economy.

In 2025–26, we continued to provide a transparent account of our decision-making through our committees and working groups, public consultations and policy updates. This included the release of a consultation report alongside our key strategic policy documents, the Pricing Framework for Australian Public Hospital Services 2026–27 and the Pricing Framework for Australian Residential Aged Care Services 2026–27. These consultation reports detail feedback received during public consultations and the rationale behind our policy decisions and pricing advice.

From 5 to 7 August 2025, we held the IHACPA Conference 2025 at the Adelaide Convention Centre, with over 550 attendees in person and online. The conference theme was ‘Integrating resilience in the care economy and the role of pricing’. An expert line up of speakers led the conversation on reform, innovation, pricing, and the opportunities for harmonisation across different sectors, including hospitals, health care and aged care. The program included keynote presentations, abstract presentations, panel sessions and workshops.

Results

The reporting of key activities in this annual report refers to the deliverables of strategic objective six: Conduct independent and transparent decision-making and engage with stakeholders in the IHACPA Work Program and Corporate Plan 2025–26, and Section 1.1 of the Portfolio Budget Statements 2025–26. A summary of each deliverable and the analysis of our performance against the deliverables is outlined in **Table 13**.

Table 13: Summary of performance for strategic objective six: Conduct independent and transparent decision-making and engage with stakeholders in 2025–26

Deliverables	Timeframe	Outcome	Analysis
1. Provide quarterly ABF activity data reports to the Pricing Authority and Jurisdictional Advisory Committee.	Ongoing	Ongoing	We provided quarterly ABF activity data reports to the Pricing Authority, Jurisdictional Advisory Committee and Technical Advisory Committee.
2. Publish evidence-based ABF related research and analysis.	Ongoing	Ongoing	As required, we conducted ABF-related research that furthers the understanding and implementation of ABF, particularly for classifications, coding standards and pricing methodologies. We will continue to work with stakeholders to improve access to hospital data, including developing appropriate safeguards and identifying opportunities that all parties are agreeable to in the release of data and/or publications to third parties.
3. Provide advice to states and territories on proposals for the trial of innovative funding models and models of care.	Ongoing	Ongoing	We continued to work with the Australian Government and New South Wales to facilitate the trialling of innovative models, through a bilateral agreement under clauses A82-84, I33-34 and Schedule D of the 2026–31 Addendum to the National Health Reform Agreement 2020–26. We also provided advice to other jurisdictions and clinical experts considering such trials.

Deliverables	Timeframe	Outcome	Analysis
4. Consider recommendations arising from the investigation into virtual models of service delivery and care, and associated funding arrangements.	December 2025	Delivered	We continued to work the Australian Government and New South Wales to facilitate the trialling of innovative models, through a bilateral agreement under clauses A97-A101 and Schedule C of the Addendum to the National Health Reform Agreement 2020-26.
5. Continue to investigate issues relating to the impact of ABF on small jurisdictions.	June 2026	Delivered	We commenced work with jurisdictions and key stakeholders to better understand the underlying cost drivers in smaller jurisdictions. We will continue to work with all jurisdictions to determine possible opportunities to address the cost variations.
6. Continue to investigate the impact and occurrence of long-stay patients in public hospitals.	June 2026	Ongoing	We commenced exploratory work to investigate the occurrence of long-stay patients in public hospitals as part of the 2024–25 work program. This work has progressed through our advisory committees and working groups in 2025–26.
7. Implement strategies, tools and working papers to ensure that IHACPA is providing information that will support our advisory committees, working groups and jurisdictions.	Ongoing	Ongoing	We continued to prepare committee papers, policy documents and technical specifications to support communication of the work program to our stakeholders.
8. Deliver the IHACPA Conference 2025.	August 2025	Delivered	We held a conference in Adelaide, South Australia, enabling continued engagement with a wide range of health and aged care stakeholders.

Deliverables	Timeframe	Outcome	Analysis
9. Develop and promote educational materials and resources to educate, inform and engage stakeholders about IHACPA's work program and our role in the health and aged care systems.	Ongoing	Ongoing	We continued to release a number of educational materials and resources, including: » webinars » fact sheets » education modules. In 2025–26, we released education modules for AR-DRG Version 12.0 on IHACPA Learn. We will continue to develop and promote other educational materials and resources for health and aged care stakeholders.

4.9 IHACPA’s assessment of refundable accommodation deposits

IHACPA assesses applications from registered aged care providers to charge accommodation payment amounts above the maximum amount determined by the Minister for Health and Ageing.

The maximum accommodation payment amount is indexed annually in line with the CPI from 1 July each year.

In compliance with relevant legislation, we provide the following information about our functions in this area.

Refundable accommodation deposit

Table 14 outlines the number of accommodation groups that were assessed by IHACPA in 2025–26.

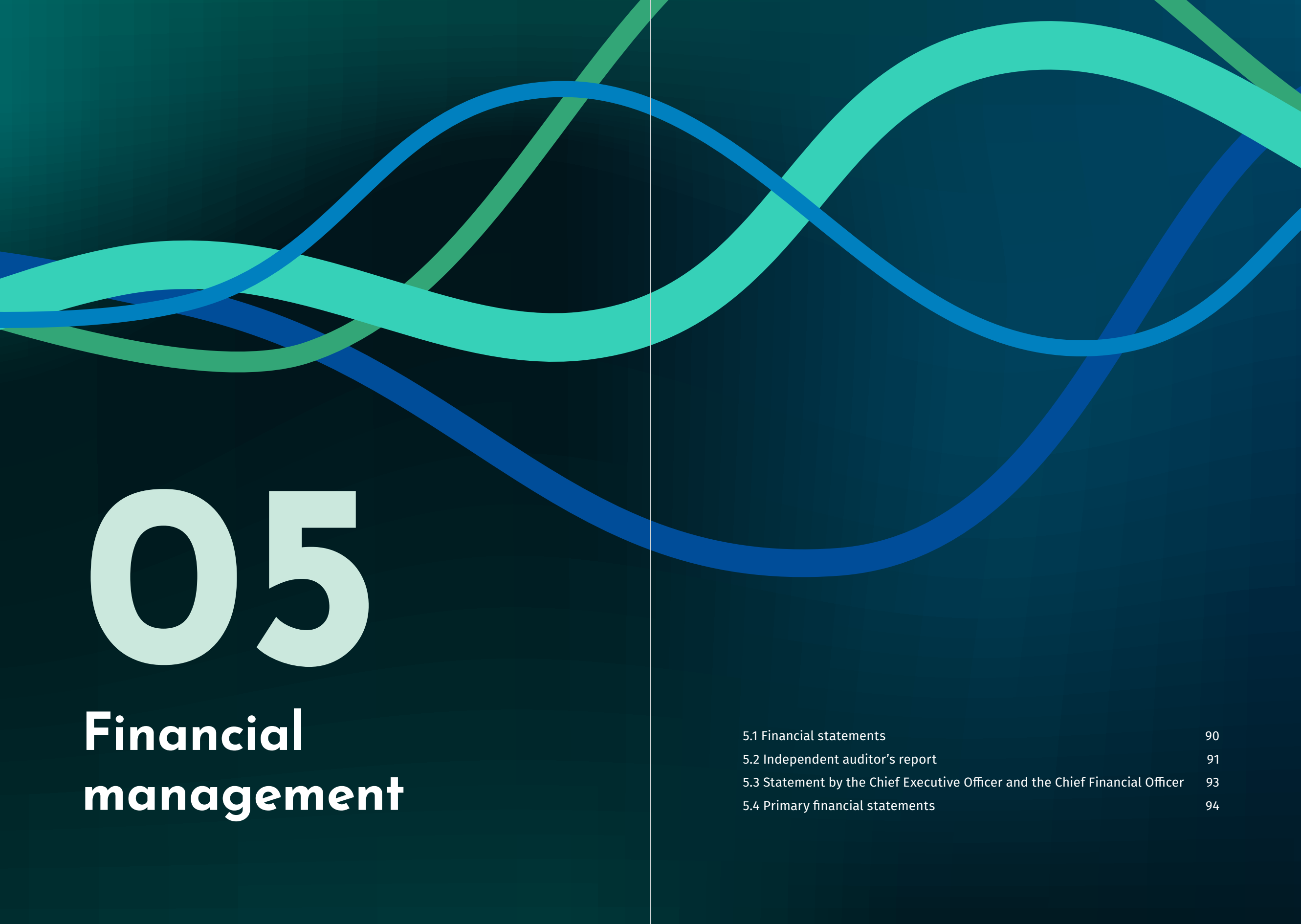
Table 14: Refundable accommodation deposit (RAD) data for financial year 2025–26

Time period	Received	Approved	Not Approved	Withdrawn	Extra Service Fee Approval (prior 1 November 2025) ⁶
Financial Year 2025–26	649	578	18	69	1

An accommodation group is a group of rooms with similar offerings at the same price point. A single submission by a provider will generally have between one and 10 accommodation groups. An accommodation group may have from one to all of the rooms in a service included within it.

During 2025–26, we received applications for 649 accommodation groups. 578 accommodation groups were approved. The number of approved accommodation groups in 2025–26 includes those within applications that may have been received prior to 2025–26.

⁶ Since the introduction of the *Aged Care Act 2024* IHACPA is no longer responsible for the approval of extra service fees.



05

Financial management

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5.1 Financial statements

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5.2 Independent auditor's report



INDEPENDENT AUDITOR'S REPORT To the Minister for Health and Ageing

Opinion

In my opinion, the financial statements of the Independent Health and Aged Care Pricing Authority (the Entity) for the year ended 30 June 2026:

- (a) comply with Australian Accounting Standards – Simplified Disclosures and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and
- (b) present fairly the financial position of the Entity as at 30 June 2026 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following as at 30 June 2026 and for the year then ended:

- Statement by the Chief Executive Officer and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement; and
- Notes to the financial statements, comprising material accounting policy information and other explanatory information.

Basis for opinion

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

Accountable Authority's responsibility for the financial statements

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

In preparing the financial statements, the Chief Executive Officer is responsible for assessing the ability of the Entity to continue as a going concern, taking into account whether the Entity's operations will cease as a result

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of an administrative restructure or for any other reason. The Chief Executive Officer is also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless the assessment indicates that it is not appropriate.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Australian National Audit Office



Anne Rainger
Executive Director
Delegate of the Auditor-General
Canberra
3 September 2026

5.3 Statement by the Chief Executive Officer and the Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2026 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 Health and Aged Care Pricing Authority will be able to pay its debts as and when they fall due.



Professor Michael Pervan

Chief Executive Officer
3 September 2026



Chris Miljak

Chief Financial Officer
3 September 2026

5.4 Primary financial statements

Statement of comprehensive income

for the period ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000	Original Budget \$'000
NET COST OF SERVICES EXPENSES				
Employee benefits	1.1A	23,085	22,447	20,607
Suppliers	1.1B	35,990	30,270	55,987
Depreciation and amortisation	2.2A	2,043	2,001	1,971
Finance costs	1.1C	135	150	136
Total expenses		61,253	54,868	78,701
OWN-SOURCE INCOME				
Own-source revenue				
Revenue from contracts with customers	1.2A	689	433	1,000
Resources received free of charge	1.2B	23,540	22,823	20,354
Interest		3,238	2,377	1,800
Other revenue	1.2C	14	-	-
Total own-source revenue		27,481	25,633	23,154
Total gains		-	-	-
Total own-source income		27,481	25,633	23,154
Net cost of services		33,772	29,235	55,547
Revenue from Government	1.2D	52,208	57,414	55,291
Surplus / (Deficit)		18,436	28,179	(256)
Surplus / (Deficit) on continuing operations		18,436	28,179	(256)
OTHER COMPREHENSIVE INCOME				
Items not subject to subsequent reclassification to net cost of services				
Changes in asset revaluation reserve		-	221	-
Total other comprehensive income		-	221	-
Total comprehensive income/(loss)		18,436	28,400	(256)

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

Budget variances commentary

Statement of comprehensive income

Total expenses of \$61.253m were \$17.448m less than budget primarily due to lower supplier expenses of \$19.997m, which were partially offset by higher employee benefits expense of \$2.478m.

Supplier expenses were lower than planned, primarily due to the rephasing of expenditure associated with costing studies. Employee benefits expenses were greater than budget due to the progressive rollout of expanded IHACPA functions.

Total own source income of \$27.481m was \$4.327m greater than budget, mainly due to higher levels of resources received free of charge. Interest was also greater than budget, reflecting higher than expected cash balances.

Revenue from Government was \$3.083m below budget, primarily due to adjustments made to offset the higher than budgeted allocation of resources received free of charge, largely relating to departmental staff seconded to IHACPA.

Statement of financial position

as at 30 June 2026

	Notes	2026 \$'000	2025 \$'000	Original Budget \$'000
ASSETS				
Financial assets				
Cash and cash equivalents	2.1A	94,415	74,160	47,206
Trade and other receivables	2.1B	1,046	1,078	1,372
Total financial assets		95,461	75,238	48,578
Non-financial assets				
Buildings (right-of-use assets)	2.2A	7,254	8,534	7,253
Leasehold improvement	2.2A	1,852	2,048	1,555
Computer software	2.2A	1,398	1,845	1,457
Other - prepayments		1,241	817	220
Total non-financial assets		11,745	13,244	10,485
Total assets		107,206	88,482	59,063
LIABILITIES				
Payables				
Suppliers	2.3A	3,675	2,435	3,021
Other payables	2.3B	20	17	18
Total payables		3,695	2,452	3,039
Interest bearing liabilities				
Lease liabilities	2.4A	8,821	9,845	8,821
Total interest bearing liabilities		8,821	9,845	8,821
Provisions				
Employee provisions	3.1A	214	145	141
Total provisions		214	145	141
Total liabilities		12,730	12,442	12,001
Net assets		94,476	76,040	47,062
EQUITY				
Contributed equity		400	400	400
Asset revaluation reserve		221	221	-
Retained surplus		93,855	75,419	46,662
Total equity		94,476	76,040	47,062

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

Budget variances commentary

Statement of financial position

Total assets of \$107.206m were \$48.143m higher than budget primarily due to the increase in cash holdings from retained surpluses.

Total liabilities of \$12.730m were \$0.729m higher than budget primarily due to higher supplier payables.

Total equity of \$94.476m was \$47.414m higher than the budget primarily due to retained surpluses noting that the budget is derived on a break-even assumption.

Statement of changes in equity

for the period ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000	Original Budget \$'000
CONTRIBUTED EQUITY				
Opening balance				
Balance carried forward from previous period		400	400	400
Closing balance as at 30 June		400	400	400
ASSET REVALUATION RESERVE				
Opening balance				
Balance carried forward from previous period		221	-	-
Other Comprehensive income		-	221	-
Closing balance as at 30 June		221	221	-
RETAINED EARNINGS				
Opening balance				
Balance carried forward from previous period		75,419	47,240	46,918
Comprehensive income				
Surplus / (deficit) for the period		18,436	28,179	(256)
Closing balance as at 30 June		93,855	75,419	46,662
TOTAL EQUITY				
Opening balance				
Balance carried forward from previous period		76,040	47,640	47,318
Equity movements during the period				
Surplus / (deficit) for the period		18,436	28,179	(256)
Other Comprehensive income		-	221	-
Closing balance as at 30 June		94,476	76,040	47,062

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

Budget variances commentary

Statement of changes in equity

Total equity of \$94.476m was \$47.414m higher than the budget amount primarily due to retained surpluses noting that the budget is derived on a break-even assumption.

Cash flow statement

for the period ended 30 June 2026

	Notes	2026 \$'000	2025 \$'000	Original Budget \$'000
OPERATING ACTIVITIES				
Cash received				
Receipts from government		52,208	57,414	55,291
Sale of goods, rendering of services, and other revenue		932	410	898
Interest		3,135	2,317	1,800
Net GST received		3,488	3,088	4,354
Total cash received		59,763	63,229	62,343
Cash used				
Employees		(1,178)	(1,177)	(1,188)
Suppliers		(37,050)	(33,141)	(59,570)
Interest payments on lease liabilities		(135)	(150)	(136)
Total cash used		(38,363)	(34,468)	(60,894)
Net cash from operating activities		21,400	28,761	1,449
INVESTING ACTIVITIES				
Cash used				
Purchase of leasehold improvements		(121)	-	-
Total cash used		(121)	-	-
Net cash used by investing activities		(121)	-	-
FINANCING ACTIVITIES				
Cash used				
Principal payments of lease liabilities		(1,024)	(958)	(1,024)
Total cash used		(1,024)	(958)	(1,024)
Net cash used by financing activities		(1,024)	(958)	(1,024)
Net increase in cash held		20,255	27,803	425
Cash and cash equivalents at the beginning of the reporting period		74,160	46,356	46,781
Cash and cash equivalents at the end of the reporting period	2.1A	94,415	74,160	47,206

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

Budget variances commentary

Statement of changes in cash flow

The closing cash balance of \$94.415m was \$47.209m higher than the budget due to retained surpluses noting that the budget is derived on a break-even assumption.

Overview

Objectives of the Independent Health and Aged Care Pricing Authority

The Independent Health and Aged Care Pricing Authority (IHACPA) is a corporate Commonwealth entity under the *Public Governance, Performance and Accountability Act 2013* (PGPA Act) with its principal place of business located at Level 12, 1 Oxford Street, Sydney NSW.

IHACPA's role and functions are set out in the *National Health Reform Act 2011* and the *Aged Care Act 2024*⁷. IHACPA's role and functions include the:

- » determination of the national efficient price and national efficient cost for public hospital services
- » development of national classifications for activity-based funding
- » resolution of disputes on cost-shifting and cross-border issues
- » provision of advice on health care pricing and costing matters
- » provision of advice on aged care pricing and costing matters
- » performance of certain functions conferred by the *Aged Care Act 2024*.

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.

⁷ On 1 November 2025, the *Aged Care Act 2024* came into effect, replacing the *Aged Care Act 1997*, *Aged Care (Transitional Provisions) Act 1997* and *Aged Care Quality and Safety Commission Act 2018*.

The financial statements have been prepared in accordance with the:

- a. Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 FRR
- b. Australian Accounting Standards and Interpretations – including simplified disclosures for Tier 2 Entities under AASB 1060 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 IHACPA during 2025–26

No significant changes affecting IHACPA functions have occurred in this reporting period.

New accounting standards

IHACPA 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 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 IHACPA's financial statements.

No accounting standard has been adopted earlier than the application date as stated in the standard.

Significant accounting judgements and estimates

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

Taxation

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

Events after the reporting period

On 27 February 2026, the Australian Government and all state and territory governments signed the Addendum, which amends the National Health Reform Agreement (NHRA) for the period 1 July 2026 to 30 June 2031 (the addendum).

The addendum establishes a renewed framework for Australian Government, state and territory cooperation in public hospital funding and broader health system reform. It provides an ambitious reform agenda, responding to persistent system pressures and demographic change. The addendum reframes the role of public hospitals within a person centred, equitable, responsive and sustainable whole of system health and care model, recognising the interdependencies between hospitals, primary care, aged care, disability services and community-based supports.

It sets 3 main objectives that all Australian governments will focus on over the next 5 years. These objectives are intended to ensure the delivery of safe, high-quality health care, in the right place, at the right time.

Objective 1 – Better health outcomes and experiences for all Australians and better value for patients.

Objective 2 – Stronger shared stewardship of the whole health system.

Objective 3 – A simpler, more equitable public hospital and health services funding model.

Consistent with the objectives, the reforms are intended to support improved patient experience and outcomes, strengthen population health, promote high-quality and evidence based care, and ensure the long term financial sustainability of the public hospital system. These objectives underpin the design of the new governance, funding and accountability arrangements introduced through the addendum.

The addendum introduces substantial reforms to national health funding, pricing, governance and accountability, many of which directly impact IHACPA's responsibilities and introduce a significant amount of work for IHACPA.

IHACPA will consult with relevant stakeholders regarding proposed implementation, including its advisory committees and working groups.

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

Notes to the financial statements

Financial performance

This section analyses the financial performance of IHACPA for the year ended 30 June 2026.

Note 1.1 Expenses

	2026 \$'000	2025 \$'000
Note 1.1A: Employee Benefits		
Wages and salaries	784	799
Superannuation - Defined contribution plans	99	101
Leave and other entitlements	368	343
Wages and salaries for staff provided by Department of Health, Disability and Ageing	21,834	21,204
Total employee benefits	23,085	22,447

Accounting policy

Employee benefits

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

	2026 \$'000	2025 \$'000
Note 1.1B: Suppliers		
Goods and services supplied or rendered		
Consultants	19,280	13,066
Contractors	7,299	8,727
IT services	6,735	5,948
Travel	486	457
Training	147	113
Publishing materials	296	533
Legal and audit expenses	245	484
Conference and seminars	731	283
Other	767	655
Total goods and services supplied or rendered	35,986	30,266
Goods supplied	349	608
Services rendered	35,637	29,658
Total goods and services supplied or rendered	35,986	30,266
Other suppliers		
Workers' compensation expenses	4	4
Total other suppliers	4	4
Total suppliers	35,990	30,270
Note 1.1C: Finance Costs		
Interest on lease liabilities (office space lease)	135	150
Total finance costs	135	150

The above lease disclosure should be read in conjunction with the accompanying notes 2.2A and 2.4A

Note 1.2 Own-source revenue and gains

OWN-SOURCE REVENUE

Note 1.2A: Revenue from contracts with customers

	2026 \$'000	2025 \$'000
Sale of goods	313	433
Rendering of services	376	-
Total revenue from contracts with customers	689	433

Sales of goods are from sales of intellectual property relating to the Australian Refined Diagnosis Related Groups (AR-DRG) classification systems. Rendering of services represent conference revenue.

Accounting policy

Revenue from contracts with customers

Revenue from the sale of goods and rendering of services is recognised when control has been transferred to the buyer.

In relation to AASB 15, IHACPA has considered each revenue stream to identify the existence of an enforceable contract that requires the completion of sufficiently specific performance obligations in exchange for relevant consideration. Revenue is recognised either over time or at a point in time as performance obligations are completed and IHACPA has an enforceable right to payment for the performance completed to date.

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 considered probable.

	2026 \$'000	2025 \$'000
Note 1.2B: Resources received free of charge		
Resources received free of charge - Departmental contribution	23,472	22,758
Resources received free of charge - Remuneration of auditors	68	65
Total resources received free of charge	23,540	22,823

Accounting policy

Resources received free of charge

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

Resources received free of charge are recorded as revenue.

	2026 \$'000	2025 \$'000
Note 1.2C: Other revenue		
Industry research subsidy	14	-
Total other revenue	14	-

Other revenue relates to research subsidy revenue received under the National Industry PhD Program.

	2026 \$'000	2025 \$'000
Note 1.2D: Revenue from Government		
Amounts from Department of Health, Disability and Ageing	52,208	57,414
Total revenue from Government	52,208	57,414

Accounting policy

Revenue from government

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

Financial position

This section analyses the IHACPA'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

	2026 \$'000	2025 \$'000
Note 2.1A: Cash and cash equivalents		
Cash on deposit	94,415	74,160
Total cash and cash equivalents	94,415	74,160

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 three months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value.

	2026 \$'000	2025 \$'000
Note 2.1B: Trade and other receivables		
Other receivables		
GST receivable from the Australian Taxation Office	701	704
Other amounts receivable	345	374
Total other receivables	1,046	1,078
Total trade and other receivables (gross)	1,046	1,078
Less expected credit loss allowance	-	-
Total trade and other receivables (net)	1,046	1,078

No amounts in receivables are overdue.

Accounting policy

Trade and other receivables

IHACPA's financial assets are comprised of trade receivables and other receivables that are held for the purpose of collecting the contractual cash flows. All of IHACPA's financial assets are measured, and carried, at amortised cost.

Impairment

All assets were assessed for impairment as at 30 June 2026. 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

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

	Buildings \$'000	Leasehold improvement \$'000	Computer Software \$'000	Total \$'000
As at 1 July 2025				
Gross book value	12,802	2,048	2,679	17,529
Accumulated depreciation, amortisation and impairment	(4,268)	-	(834)	(5,101)
Total as at 1 July 2025	8,534	2,048	1,845	12,427
Additions				
Purchase or internally developed (including work in progress)	-	121	-	121
Depreciation and amortisation	-	(316)	(447)	(763)
Depreciation on right-of-use assets	(1,280)	-	-	(1,280)
Total as at 30 June 2026	7,254	1,852	1,398	10,504
Total as at 30 June 2026 represented by				
Gross book value	12,802	2,168	2,679	17,649
Accumulated depreciation, amortisation and impairment	(5,548)	(316)	(1,281)	(7,145)
Total as at 30 June 2026 represented by	7,254	1,852	1,398	10,504
Carrying amount of right-of-use assets	7,254	-	-	7,254

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

The balances detailed above are rounded which may result in discrepancies between totals and the sum of components.

Summary of asset movements:

During the period, \$0.121m of additional office fit-out costs were capitalised.

Accounting policy

Property, plant and equipment, and intangibles

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

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

Asset recognition threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases costing less than \$10,000 (2025: \$10,000), 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).

Lease right-of-use (ROU) assets

Leased ROU assets are capitalised at the commencement date of the lease and comprise of the initial lease liability amount, initial direct costs incurred when entering into the lease less any lease incentives received. These assets are accounted for by Commonwealth lessees as separate asset classes to corresponding assets owned outright, but included in the same column as where the corresponding underlying assets would be presented if they were owned. Lease ROU assets continue to be measured at cost after initial recognition.

Revaluations

Following initial recognition at cost, property, plant and equipment (excluding ROU assets) 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:

	2026	2025
Leasehold improvements	Lease terms	Lease terms
Plant and equipment	3 to 6 years	3 to 6 years

Impairment

All assets were assessed for impairment at 30 June 2026. 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 6 years (2025: 1 to 6 years). All software assets were assessed for indications of impairment as at 30 June 2026.

Note 2.3 Payables

Note 2.3A: Suppliers

Trade creditors and accruals	3,675	2,337
Contract liabilities from contracts with customers	-	98
Total suppliers	3,675	2,435

Trade creditors settlement terms are 30 days.

The contract liabilities from contracts with customers are associated with prepaid conference revenue.

Note 2.3B: Other Payables

Salaries and wages	20	17
Total other payables	20	17

Note 2.4 Interest bearing liabilities

	2026 \$'000	2025 \$'000
Note 2.4A: Lease liabilities		
Lease liability (office space)	8,821	9,845
Total lease liabilities	8,821	9,845

Total cash outflow for leases for the year ended 30 June 2026 was \$1.159m (2025: \$1.108m)

Maturity analysis - contractual undiscounted cash flows

Within 1 year	1,320	1,159
Between 1 to 5 years	6,692	6,252
More than 5 years	1,201	2,961
Total undiscounted leases	9,213	10,372

The lease for IHACPA's office space at Level 12, 1 Oxford Street Sydney commenced on 1 March 2022 for a term of 5 years (with a 5 year extension option).

People and relationships

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

Note 3.1 Employee provisions

	2026 \$'000	2025 \$'000
Note 3.1A: Employee provisions		
Leave	214	145
Total employee provisions	214	145

Accounting policy

Employee provisions

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

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

Leave

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

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

Superannuation

The entity's staff are members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), or the PSS accumulation plan (PSSap), or other superannuation funds held outside the Australian Government. The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap is a defined contribution scheme.

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

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

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

Note 3.2 Key management personnel remuneration

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

Key management personnel remuneration is reported in the table below:

	2026 \$'000	2025 \$'000
Short-term employee benefits	1,110	1,097
Post-employment benefits	94	92
Other long-term benefits	14	12
Termination benefits	-	-
Total key management personnel remuneration expenses	1,218	1,201

The total number of key management personnel that are included in the above table is 9 (2025: 10).

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

Note 3.3 Related party disclosures

Related party relationships

IHACPA is an Australian Government controlled entity. Related parties to this entity are the key management personnel (as per Note 3.2) 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 IHACPA, it has been determined that there are no related party transactions to be separately disclosed.

Managing uncertainties

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

Note 4.1 Contingent assets and liabilities

Quantifiable contingencies

There were no quantifiable contingent assets or liabilities in this reporting period (2025: nil).

Unquantifiable contingencies

There were no unquantifiable contingent assets or liabilities in this reporting period (2025: nil).

Significant remote contingencies

There were no significant remote contingent assets or liabilities in this reporting period (2025: nil).

Accounting policy

Contingent assets and liabilities

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

Note 4.2 Financial instruments

	2026 \$'000	2025 \$'000
Note 4.2A: Financial instruments (assets)		
Financial assets at amortised cost		
Cash and cash equivalents	94,415	74,160
Trade and other receivables	345	374
Total financial assets at amortised cost	94,760	74,534
Note 4.2B: Financial instruments (liabilities)		
Financial liabilities measured at amortised cost		
Trade creditors and accruals	3,675	2,337
Contract liabilities from contracts with customers	-	98
Total financial liabilities measured at amortised cost	3,675	2,435

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 three months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value.

Classification and measurement

The classification and measurement of IHACPA's financial assets under AASB 9 is determined by its business model for managing its financial assets and the contractual cash flow characteristics of those assets.

Financial assets

IHACPA's financial assets are comprised of trade receivables and other receivables that are held for the purpose of collecting the contractual cash flows. All of IHACPA's financial assets are measured, and carried, at amortised cost.

Financial liabilities

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

Impairment

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

Due to the nature of IHACPA's receivables, a nil loss allowance has been calculated. There is no impairment of IHACPA's financial assets as at 30 June 2026.

Note 4.3 Fair value measurement

Accounting policy

As allowed for by AASB 13 *Fair Value Measurement*, quantitative information on significant unobservable inputs used in determining fair value is not disclosed.

Assets held at fair value include leasehold improvements and property, plant and equipment. Assets not held at fair value include computer software and Right-of-Use (ROU) assets.

IHACPA 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). An independent revaluation was undertaken by Jones Lang LaSalle Public Sector Valuations Pty Ltd in June 2025 in accordance with the valuation methodologies outlined below. This revaluation resulted in a fair value adjustment to leasehold improvement assets, which was recognised through movements in the asset revaluation reserve.

If a particular asset class experiences significant and volatile changes in fair value (that is, 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.

The categories of fair value measurement are:

- Level 1: quoted prices (unadjusted) in active markets for identical assets 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, either directly or indirectly.
- Level 3: unobservable inputs.

IHACPA's assets are held at fair value and are measured at category Levels 2 or 3 with no fair values measured at category Level 1.

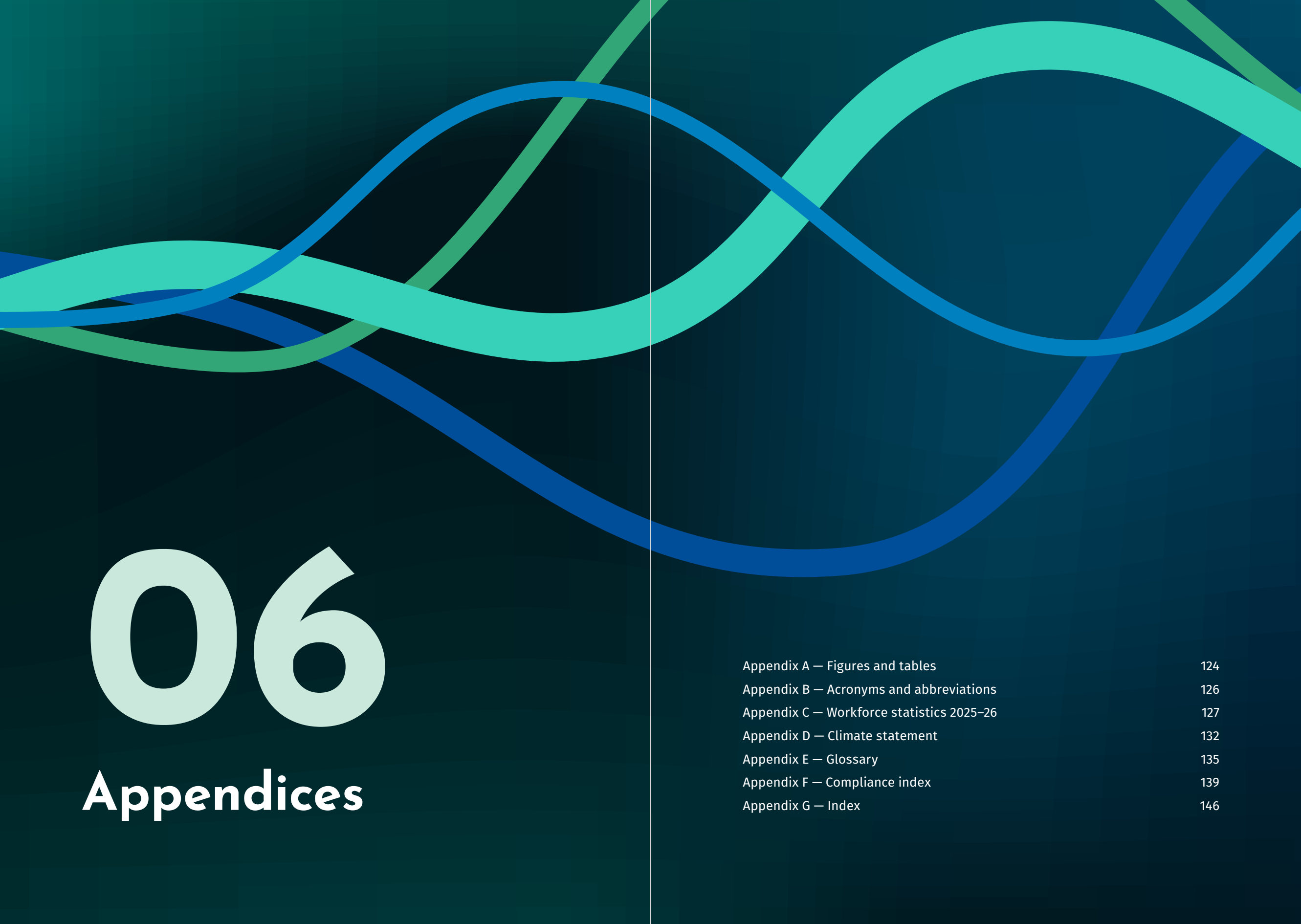
Leasehold improvements are measured at category Level 3 and the valuation methodology used is Current Replacement Cost (CRC). Under CRC the estimated cost to replace the asset is calculated, with reference to new replacement price per square metre, and then adjusted to take into account its consumed economic benefit (accumulated depreciation). The consumed economic benefit has been determined based on the professional judgement with regard to physical, economic and external obsolescence factors.

Property, plant and equipment is measured at either category Level 2 or 3. The valuation methodology is either market approach or CRC, based on replacement cost for a new equivalent asset. The significant unobservable inputs used in the fair value measurement of property, plant and equipment assets are the market demand and professional judgement.

Other information

Note 5.1 Current/non-current distinction for assets and liabilities

	2026 \$'000	2025 \$'000
Note 5.1A Current/non-current distinction for assets and liabilities		
Assets expected to be recovered in:		
No more than 12 months		
Cash and cash equivalents	94,415	74,160
Trade and other receivables	1,046	1,078
Prepayments	918	817
Total no more than 12 months	96,379	76,055
More than 12 months		
Buildings	7,254	8,534
Leasehold improvements	1,852	2,048
Computer software	1,398	1,845
Prepayments	323	-
Total more than 12 months	10,827	12,427
Total assets	107,206	88,482
Liabilities expected to be settled in:		
No more than 12 months		
Suppliers	3,675	2,435
Leases	1,200	1,024
Other payables	20	17
Employee provisions	174	120
Total no more than 12 months	5,069	3,596
More than 12 months		
Leases	7,621	8,821
Employee provisions	40	25
Total more than 12 months	7,661	8,846
Total liabilities	12,730	12,442



06

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Appendix B – Acronyms and abbreviations

ABF - Activity-based funding
ACAC - Aged Care Advisory Committee
ACCHO - Aboriginal Community Controlled Health Organisation
ACHI - Australian Classification of Health Interventions
ACN - Aged Care Network
ACS - Australian Coding Standards
AECC - Australian Emergency Care Classification
AHPCS - Australian Hospital Patient Costing Standards
AMHCC - Australian Mental Health Care Classification
AN-ACC - Australian National Aged Care Classification
ANAO - Australian National Audit Office
AN-APP - Australian Non-Admitted Patient Classification Project
AN-SNAP - Australian National Subacute and Non-Acute Patient Classification
ADRG - Adjacent Diagnosis Related Group
ARCC - Audit Risk and Compliance Committee
AR-DRG - Australian Refined Diagnosis Related Groups
ATTC - Australian Teaching and Training Classification
CAC - Clinical Advisory Committee
CEO - Chief Executive Officer
CPI - Consumer Price Index
CSS - Commonwealth Superannuation Scheme
DCID - Diagnosis cluster identifier
EPD Short List - Emergency Care ICD-10-AM Thirteenth Edition Principal Diagnosis Short List
ICD-10-AM - International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICD-11 - International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision
MPSP - Multi-Purpose Services Program
NATSIFACP - National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NEC - National efficient cost
NEP - National efficient price
NHCDC - National Hospital Cost Data Collection
NHRA - National Health Reform Agreement
NHR Act - *National Health Reform Act 2011*

PGPA Act - *Public Governance, Performance and Accountability Act 2013*
PSS - Public Sector Superannuation Scheme
RAD - Refundable accommodation deposit
Tier 2 - Tier 2 Non-Admitted Services Classification
WHS Act - *Work Health and Safety Act 2011*

Appendix C – Workforce statistics 2025–26

Ongoing and non-ongoing employees

With the exception of the IHACPA CEO, our staff are seconded from the department under a memorandum of understanding between the Pricing Authority and the department. The department reports on our staff in its workforce statistics tables. For transparency, we also provide the following staffing tables for staff working with us under the direction of our CEO.

Table 15: Ongoing seconded employees at 30 June 2026

	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total
NSW	34	1	35	93	10	103	0	0	0	0	0	0	0	0	138
Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vic	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ACT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
External Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Overseas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	34	1	35	93	10	103	0	0	0	0	0	0	0	0	138

Table 16: Non-ongoing seconded employees at 30 June 2026

Main/male				Woman/female			Non-binary			Prefers not to answer			Uses a different term		
	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total
NSW	6	0	6	10	0	10	0	0	0	0	0	0	0	0	16
Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vic	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ACT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NT	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
External Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Overseas	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	6	0	6	10	0	10	0	0	0	0	0	0	0	0	16

Table 17: Ongoing seconded employees at 30 June 2025

Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term		
Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total
NSW	33	1	34	78	11	89	0	0	0	0	0	0	0	123
Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tas	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vic	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ACT	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NT	-	-	-	-	-	-	-	-	-	-	-	-	-	-
External Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Overseas	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	33	1	34	78	11	89	0	0	0	0	0	0	0	123

Table 18: Non-ongoing seconded employees at 30 June 2025

Man/Male			Woman/Female			Non-binary			Prefers not to answer			Uses a different term		
Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total	Full-time	Part-time	Total
NSW	1	0	1	8	0	8	0	0	0	0	0	0	0	9
Qld	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SA	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tas	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Vic	-	-	-	-	-	-	-	-	-	-	-	-	-	-
WA	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ACT	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NT	-	-	-	-	-	-	-	-	-	-	-	-	-	-
External Territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Overseas	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	1	0	1	8	0	8	0	0	0	0	0	0	0	9

Appendix D – Climate statement

Ecologically sustainable development and environmental performance

IHACPA does not undertake any substantive work that is covered by section 516A of the [Environment Protection and Biodiversity Conservation Act 1999](#) (EPBC Act).

Australian Public Service Net Zero 2030

As part of the reporting requirements under section 516A of the *Environment Protection and Biodiversity Conservation Act 1999*, and in line with the Government's Australian Public Service Net Zero 2030 policy, all non-corporate Commonwealth entities and corporate Commonwealth entities are required to publicly report on the emissions from their operations.

The Greenhouse Gas Emissions Inventory and Electricity Greenhouse Gas Emissions tables below presents greenhouse gas emissions over the 2025-2026 period. Results are on the basis of Carbon Dioxide Equivalent (CO₂-e) emissions. Greenhouse gas emissions reporting has been developed with methodology that is consistent with the Whole-of-Australian Government approach as part of the APS Net Zero 2030 policy.

Table 19: 2025–26 Greenhouse Gas Emissions Inventory – Location-based

Emission source	Scope 1 t CO ₂ -e	Scope 2 t CO ₂ -e	Scope 3 t CO ₂ -e	Total t CO ₂ -e
Electricity (Location-based approach)	n/a	32.23	1.52	33.75
Natural gas	-	n/a	-	-
Solid waste	-	n/a	-	-
Refrigerants	-	n/a	n/a	-
Fleet and other vehicles	-	n/a	-	-
Domestic commercial flights	-	n/a	21.08	21.08
Domestic hire car	n/a	n/a	0.23	0.23

Emission source	Scope 1 t CO ₂ -e	Scope 2 t CO ₂ -e	Scope 3 t CO ₂ -e	Total t CO ₂ -e
Domestic travel accommodation	n/a	n/a	1.77	1.77
Other energy	-	n/a	-	-
Total t CO₂-e	-	32.23	24.60	56.83

Note: **Table 19** presents emissions related to electricity usage using the location-based accounting method. CO₂-e = Carbon Dioxide Equivalent. Solid waste data was unable to be separated from landlord data and has not been included.

n/a = not applicable

Table 20: 2025–26 Electricity Greenhouse Gas Emissions

Emission source	Scope 2 t CO ₂ -e	Scope 3 t CO ₂ -e	Total t CO ₂ -e	Electricity kWh
Electricity (Location based approach)	32.23	1.52	33.75	50,351.87
Market-based electricity emissions	33.74	4.59	38.33	41,646.04
Total renewable electricity consumed	n/a	n/a	n/a	8,705.84
Renewable power percentage ⁸	n/a	n/a	n/a	8,705.84
Jurisdictional renewable power percentage ^{9,10}	n/a	n/a	n/a	-
GreenPower ⁹	n/a	n/a	n/a	-
Large-scale generation certificates ⁹	n/a	n/a	n/a	-
Behind the meter solar ¹¹	n/a	n/a	n/a	-
Total renewable electricity produced	n/a	n/a	n/a	-
Large-scale generation certificates ⁹	n/a	n/a	n/a	-
Behind the meter solar ¹¹	n/a	n/a	n/a	-

⁸ Listed as Mandatory renewables in 2024–25 Annual Reports. The renewable power percentage (RPP) accounts for the portion of electricity used, from the grid, that falls, within the Renewable Energy Target (RET).

⁹ Listed as Voluntary renewables in 2023-24 Annual Reports.

¹⁰ The Australian Capital Territory is currently the only state with a jurisdictional renewable power percentage (JRPP).

¹¹ Reporting behind the meter solar consumption and/or production is optional. The quality of data is expected to improve over time as emissions reporting matures.

Note: **Table 20** presents emissions related to electricity usage using both the location-based and the market-based accounting methods. CO₂-e = Carbon Dioxide Equivalent. Electricity usage is measured in kilowatt hours (kWh).

n/a = not applicable

Notes on Scopes:

- » Scope 1 emissions are emissions from direct consumption of fuels or refrigerants (for example, running a fleet of vehicles). IHACPA had no scope 1 emissions.
- » Scope 2 emissions are indirect emissions from the generation of purchased energy, from a utility provider and relate to electricity usage at IHACPA's office space. Electricity transmission and distribution losses are included in scope 3.
- » Scope 3 emissions are all indirect emissions not included in scope 2 that occur in the value chain including both upstream and downstream emissions. IHACPA's scope 3 emissions primarily represent domestic flight emissions relating to the IHACPA CEO and Pricing Authority. Domestic flight emissions relating to staff seconded to IHACPA from the Department of Health, Disability and Ageing are included in the department's emissions disclosure.

Appendix E – 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 (ABF) uses national classifications, cost weights and the national efficient price (NEP) to determine the amount of funding for each activity or service.

Aged Care Act 1997

On 12 August 2022, the *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* and the *Aged Care Legislation Amendment (Independent Health and Aged Care Pricing Authority) Instrument 2022* amended the *National Health Reform Act 2011* and the *Aged Care Act 1997*, and in so doing expanded IHACPA's remit. The changes also transferred the functions of the former Office of the Aged Care Pricing Commissioner to IHACPA.

Aged Care Act 2024

The Australian Parliament passed the [Aged Care Act 2024](#) as the new law for government-funded aged care on 25 November 2024. The *Aged Care Act 2024* commenced on 1 November 2025 and replaces the *Aged Care Act 1997*, *Aged Care (Transitional Provisions) Act 1997*, and *Aged Care Quality and Safety Commission Act 2018*.

Block funding

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

Corporate plan

The primary strategic planning document of a Commonwealth Government entity. It sets out the objectives, capabilities and intended results over a 4-year period, in accordance with the entity's stated purposes. The corporate plan should provide a clear line of sight of the relevant annual performance statement, Portfolio Budget Statement and annual report.

National Agreement on Closing the Gap

The [National Agreement on Closing the Gap](#) is a partnership between the Australian governments and Aboriginal and Torres Strait Islander organisations to address inequality and improve life outcomes for Indigenous Australians. The agreement commenced on 30 July 2020, replacing the earlier National Indigenous Reform Agreement and introducing a more inclusive and collaborative approach.

National efficient cost

IHACPA determines a national efficient cost (NEC) for services that are not suitable for ABF, such as small rural hospitals. The NEC determines the government's contribution to block-funded hospitals.

National efficient price

A base price calculated by IHACPA as a benchmark to guide governments about the level of funding that would meet the average cost of providing acute care (admitted, emergency and outpatient) services in public hospitals across Australia. The NEP is based on the projected average cost of a national weighted activity unit after the deduction of specified Commonwealth Government funded programs.

National Health Reform Act 2011

IHACPA 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 [National Health Reform Agreement](#) (NHRA) outlines the funding, governance and performance arrangements for the delivery of public hospital services in Australia. The agreement was entered into by the Australian Government and all states and territories in August 2011.

The [Addendum to the National Health Reform Agreement 2020–25](#) was extended for 12 months to expire on 30 June 2026, to enable the continued negotiation of a new addendum from 1 July 2026 to 30 June 2031.

On 27 February 2026, the Commonwealth and all state and territory governments signed the [Addendum to the National Health Reform Agreement 2026–31](#), that covers the period of 1 July 2026 to 30 June 2031.

National Hospital Cost Data Collection

The National Hospital Cost Data Collection (NHCDC) is the collection of patient level activity across Australian hospitals, and is the primary data collection used to develop the national efficient price determination for the funding of public hospital services. The process is performed with the states and territories and private hospitals, who submit cost data to the NHCDC on an annual basis.

Public Governance, Performance and Accountability Act 2013

The *Public Governance, Performance and Accountability Act 2013* (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 Government entities and companies.

Refundable Accommodation Deposit

A Refundable Accommodation Deposit (RAD) is a lump-sum payment made by a resident for a room (or part of a room) in an approved residential care home. The price is for residents who are not eligible for government assistance. Each approved residential care home sets their own price for different kinds of rooms. RADs provide a significant source of funding for capital investment and act as an interest-free loan to providers. It is refundable when the resident leaves care, minus any agreed deductions and/or applicable retention amounts.

Three year data plan

Under the NHRA, IHACPA is required to prepare a three year data plan each year to show what data it will need in the future. This plan is shared with the Australian Government and state and territory governments. It sets out what data IHACPA needs for public hospital funding over the next 3 years, how and when the data will be collected, and what types of data and classifications support our advice on pricing and costs.

Work program

Each year, IHACPA consults on and publishes a work program for the year ahead. As prescribed in section 225 of the *National Health Reform Act 2011*, the work program sets out IHACPA's program of work for the coming year and invites interested persons, including states and territories, to make submissions to the Pricing Authority within 30 days of publication. Work programs are available at ihacpa.gov.au/publications.

Appendix F – Compliance index

IHACPA, as a corporate Commonwealth entity, has prepared this annual report under section 17BE(u) of the Public Governance, Performance and Accountability Rule 2014 (PGPA Rule), and section 46 of the PGPA Act.

PGPA Rule reference	Part of report	Page	Description	Requirement
17BE	Contents of annual report			
17BE(a)	Introduction	8	Details of the legislation establishing the body.	Mandatory
17BE(b)(i)	What we do	11-13	A summary of the objects and functions of the entity as set out in legislation.	Mandatory
17BE(b)(ii)	What we do	11-13	The purposes of the entity as included in the entity's corporate plan for the reporting period.	Mandatory
17BE(c)	Responsible minister	13	The names of the persons holding the position of responsible minister or responsible ministers during the reporting period, and the titles of those responsible ministers.	Mandatory
17BE(d)	Ministerial directions and government policy orders	13	Directions given to the entity by the minister under an Act or instrument during the reporting period.	If applicable, mandatory
17BE(e)	Not applicable	-	Any government policy order that applied in relation to the entity during the reporting period under section 22 of the PGPA Act.	If applicable, mandatory

PGPA Rule reference	Part of report	Page	Description	Requirement
17BE(f)	Not applicable	-	Particulars of non-compliance with: a. direction given to the entity by the minister under an Act or instrument during the reporting period; or b. government policy order that applied in relation to the entity during the reporting period under section 22 of the PGPA Act.	If applicable, mandatory
17BE(g)	Annual performance statements	56-87	Annual performance statements in accordance with paragraph 39(1)(b) of the PGPA Act and section 16F of the rule.	Mandatory
17BE(h), 17BE(i)	Not applicable	-	A statement of significant issues reported to the minister under paragraph 19(1)(e) of the PGPA Act that relates to non-compliance with finance law and action taken to remedy non-compliance.	If applicable, mandatory
17BE(j)	Approval by accountable authority	iii	Information on the accountable authority, or each member of the accountable authority, of the entity during the reporting period.	Mandatory
17BE(k)	Organisational structure	20-21	Outline of the organisational structure of the entity, including any subsidiaries of the entity.	Mandatory

PGPA Rule reference	Part of report	Page	Description	Requirement
17BE(ka)	Appendix C – IHACPA workforce statistics	127-131	Statistics on the entity's employees on an ongoing and non-ongoing basis, including the following: a. statistics on full-time employees b. statistics on part-time employees c. statistics on gender d. statistics on staff location.	Mandatory
17BE(l)	Organisational structure	20	Outline of the location, whether or not in Australia, of major activities or facilities of the entity.	Mandatory
17BE(m)	Key corporate governance practices	48-51	Information relating to the main corporate governance practices used by the entity during the reporting period.	Mandatory

PGPA Rule reference	Part of report	Page	Description	Requirement
17BE(n), 17BE(o)	Not applicable	-	For transactions with a related Commonwealth entity or related company where the value of the transaction, or if there is more than one transaction, the aggregate of those transactions, is more than \$10,000 (inclusive of GST): a. the decision-making process undertaken by the accountable authority to approve the entity paying for a good or service from, or providing a grant to, the related Commonwealth entity or related company, and b. the value of the transaction, or if there is more than one transaction, the number of transactions and the aggregate of value of the transactions.	If applicable, mandatory
17BE(p)	The National Health Reform Agreement 2026–31	14	Any significant activities and changes that affected the operation or structure of the entity during the reporting period.	If applicable, mandatory
17BE(q)	Not applicable	-	Particulars of judicial decisions or decisions of administrative tribunals that may have a significant effect on the operations of the entity.	If applicable, mandatory

PGPA Rule reference	Part of report	Page	Description	Requirement
17BE(r)	Not applicable	-	Particulars of any reports on the entity given by: a. the Auditor-General (other than a report under section 43 of the Act); or b. Parliamentary Committee; or c. the Commonwealth Ombudsman; or d. the Office of the Australian Information Commissioner.	If applicable, mandatory
17BE(s)	Not applicable	-	An explanation of information not obtained from a subsidiary of the entity and the effect of not having the information on the annual report.	If applicable, mandatory
17BE(t)	Not applicable	-	Details of any indemnity that applied during the reporting period to the accountable authority, any member of the accountable authority or officer of the entity against a liability (including premiums paid, or agreed to be paid, for insurance against the authority, member or officer's liability for legal costs).	If applicable, mandatory

PGPA Rule reference	Part of report	Page	Description	Requirement
17BE(taa)	Audit, Risk and Compliance Committee	48-51	The following information about the audit committee for the entity: a. a direct electronic address of the charter determining the functions of the audit committee b. the name of each member of the audit committee c. the qualifications, knowledge, skills or experience of each member of the audit committee d. information about each member's attendance at meetings of the audit committee e. the remuneration of each member of the audit committee.	Mandatory
17BE(ta)	Key management personnel	115-116	Information about executive remuneration.	Mandatory
17BF	<i>Disclosure requirements for government business enterprises</i>			
17BF(1)(a)(i)	Not applicable	-	An assessment of significant changes in the entity's overall financial structure and financial conditions.	If applicable, mandatory
17BF(1)(a)(ii)	Not applicable	-	An assessment of any events or risks that could cause financial information that is reported not to be indicative of future operations or financial conditions.	If applicable, mandatory
17BF(1)(b)	Not applicable	-	Information on dividends paid or recommended.	If applicable, mandatory

PGPA Rule reference	Part of report	Page	Description	Requirement
17BF(1)(c)	Not applicable	-	Details of any community service obligations the government business enterprise has including: a. an outline of actions taken to fulfil those obligations b. an assessment of the cost of fulfilling those obligations.	If applicable, mandatory
17BF(2)	Not applicable	-	A statement regarding the exclusion of information on the grounds that the information is commercially sensitive and would be likely to result in unreasonable commercial prejudice to the government business enterprise.	If applicable, mandatory

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